

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery General Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>13311 Andrew Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mildred</u> <u>(NM)</u> <u>Acorn</u> 4. DATE OF DEATH Month Day Year <u>April</u> <u>16</u> <u>19 66</u>						5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>8/2/91</u> 9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>WASH, D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						13. FATHER'S NAME <u>unknown</u> <u>GEORGE WEST</u> 14. MOTHER'S MAIDEN NAME <u>unknown</u> <u>ELLA JANE CLOUGH</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Edward M. Acorn</u> Address <u>13311 Andrew Drive</u> <u>hospital records</u> <u>Silver Spring, Md.</u>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> DUE TO (b) <u>490X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>6</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>3/12/66</u> to <u>4/16/66</u> , that (I) (we) last saw the deceased alive on <u>4/16/66</u> , and that death occurred at <u>11:20 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u> 22c. PHYSICIAN'S NAME (Type) <u>Charles H. Ligon, M.D.</u> 22d. ADDRESS <u>Sandy Spring, Md.</u>						22b. DATE SIGNED <u>4/18/66</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>21 April 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>						24. FUNERAL DIRECTOR <u>Shubert Thomas</u> <u>8434 Georgia Avenue</u> <u>Warner E. Humphrey, Inc.</u> <u>Silver Spring, Md.</u> 25a. REC'D BY REGISTRAR <u>APR 21 1966</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

CERTIFICATE OF DEATH

05440

05440

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> 15-1	
c. LENGTH OF STAY in 1b <u>8 days</u>		d. STREET ADDRESS <u>Rt. #1-Box 137</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dona</u> Middle <u>Addison</u> Last <u>Addison</u>		4. DATE OF DEATH Month <u>4</u> Day <u>11</u> Year <u>19 66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/25/1881</u> 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Scott Macbee</u>		14. MOTHER'S MAIDEN NAME <u>Mary Togood</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Jacome Dosey-daughter-Same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 Hypertensive cardiovascular and disor</u> DUE TO (b) <u>Arteriosclerotic Heart disease</u> DUE TO (c) <u>year</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 2, 1966</u> to <u>April 11, 1966</u> that (I) (we) last saw the deceased alive on <u>April 9, 1966</u> , and that death occurred at <u>5 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>E. Bonduelle Hunter Jr. M.D.</u>		22b. DATE SIGNED <u>April 11, 1966</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL <u>Interment</u>		23b. DATE THEREOF <u>4-16-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove.,</u>		23d. LOCATION (City or Town) (County) (State) <u>Laytonsville, Md.</u>	
24. FUNERAL DIRECTOR <u>Robert L. Sumner</u>		ADDRESS <u>Rockville, Md.</u>	
25a. REC'D BY REGISTRAR <u>APR 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17-3-71

STATE OF TEXAS

17-3-71

APR 1 1971

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
GM 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>11 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>1841 Columbian Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Arturo</u> First Middle Last		4. DATE OF DEATH <u>April</u> Month Day Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/27/20</u> 9. AGE (In years last birthday) <u>46</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Angelo Agazzi</u>		14. MOTHER'S MAIDEN NAME <u>Maria Tomossini</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>578-40-5240</u>	
17. INFORMANT <u>Wanda Agazzi</u> Address <u>Same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>CORONARY INSUFFICIENCY, AORTIC</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY ARTERIOSCLEROSIS, SEVERE</u> DUE TO <u>4201</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4/2/66</u> 22. DATE SIGNED	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5 APR. 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MOUNT OLIVET CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON DC.</u>
24. FUNERAL DIRECTOR <u>RINALDI FUNERAL HOME INC 7400 GEORGIA AVE. N.W.</u>		25a. RECEIVED BY REGISTRAR <u>APR 5 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

1957

[Faint, illegible handwritten text covering the majority of the page]

APR 2 1957

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05442				CERTIFICATE OF DEATH				05442			
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Va.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park						c. LENGTH OF STAY IN ID 5 days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanatorium & Hospital						e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Falmouth					
3. NAME OF DECEASED (Type or print) First mac						4. DATE OF DEATH Month april					
5. SEX female						6. COLOR OR RACE white					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>						8. DATE OF BIRTH 2-3-05					
9. AGE (in years last birthday) 61 yrs.						10. IF UNDER 1 YEAR Months Days Hours Min.					
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant owner						12. BIRTHPLACE (County & State, or foreign country) Va.					
13. FATHER'S NAME Archie Harding						14. MOTHER'S MAIDEN NAME Virginia O'Brien					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no						16. SOCIAL SECURITY NO.					
17. INFORMANT Hospital Records						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 ventricular fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial infarction DUE TO (c) arteriosclerosis obliterans					
19. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hiatus hernia - esophageal - postop						20. INTERVAL BETWEEN ONSET AND DEATH minutes hours years					
21. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						22. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
23. 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						24. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
25. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						26. 20f. (City or town) (County) (State)					
27. 21. I certify that (I) (this hospital) attended the deceased from 3/30, 1966, to 4/3, 1966, that (I) (we) last saw the deceased alive on 4/3, 1966, and that death occurred at 12:54 AM, from the causes and on the date stated above.											
28. 22a. SIGNATURE Kenneth Cruze						29. 22b. DATE SIGNED 4/3/66					
30. 22c. PHYSICIAN'S NAME (Type) KENNETH CRUZE, M.D.						31. 22d. ADDRESS 831 UNIVERSITY BLVD E, AYATTSVILLE MD					
32. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						33. 23b. DATE THEREOF Apr. 6, 1966					
34. 23c. NAME OF CEMETERY OR CREMATORY Berea Church Cemetery						35. 23d. LOCATION (City, town or county) (State) Stafford County, Va.					
36. 24. FUNERAL DIRECTOR Warner E. Humphreys						37. 25a. REC'D BY REGISTRAR APR 11 1966					
38. 25b. REGISTRAR'S SIGNATURE Charles Judge											

115-84

115-84

Kenneth C. Case, Jr. 21 January 1952

49811 1952
115-84

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

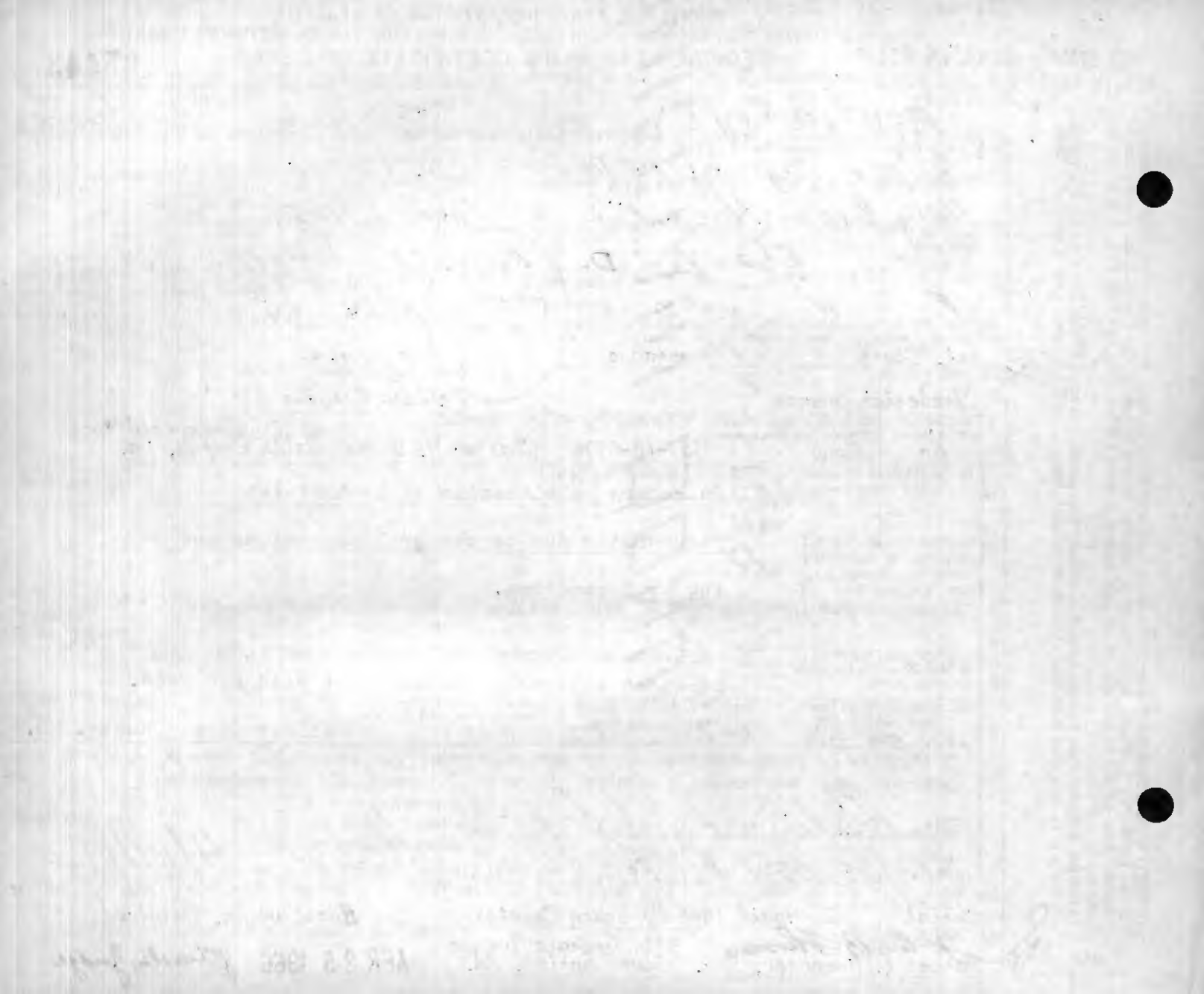
05443

05443

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>15 Days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>12501 Littleton Street</u>			
3. NAME OF DECEASED (Type or print) First <u>ELZEY</u> Middle <u>D.</u> Last <u>ALLNUTT</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>19</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1890</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick Duncan</u>			14. MOTHER'S MAIDEN NAME <u>Melissa Burgess</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-10-0536</u>		17. INFORMANT <u>Charles H. Duncan</u> Address <u>3827 Summerfield Road, Falls Church, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolization with bilateral</u> <u>983X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pneumonitis due to cerebral contusions and</u> DUE TO (c) <u>subdural hematoma.</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased allegedly beaten about head and face.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>3:00</u> pm <u>4/4</u> 19 <u>66</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Silver Spring Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>							22. DATE SIGNED <u>4/19/1966</u>
ACTUAL SIGNATURE <u>Belden R. Reap</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>12501 Littleton Street, Silver Spring, Md.</u>					
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>22 April 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Rehobothville, Maryland</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Avenue, Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 15 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY Little Falls c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 77 Lower Notch Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Carol Marie Alschen					4. DATE OF DEATH Month Day Year April 5 19 66				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 August 1939		9. AGE (in years last birthday) 26 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) IBM Operator				10b. KIND OF BUSINESS OR INDUSTRY Unascertainable		11. BIRTHPLACE (County & State, or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Giannetti					14. MOTHER'S MAIDEN NAME Ann Pache				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 144-30-4203		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md. 20014					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of vomitus DUE TO (b) Hepatic failure DUE TO (c) Hodgkins Disease CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH 4 minutes 3 weeks 2 years
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that he (this hospital) attended the deceased from March 21, 1966 to April 5, 1966 , that he (we) last saw the deceased alive on April 5, 1966 , and that death occurred at 2:45 M., from the causes and on the date stated above.									
22a. SIGNATURE <i>Alexander A. Levitan</i>					22b. DATE SIGNED 5 April 1966				
22c. PHYSICIAN'S NAME (Type) Alexander A. Levitan, M.D.					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 6, 1966		23c. NAME OF CEMETERY OR CREMATORY Holy Sepulcher		23d. LOCATION (City, town or county) (State) Totowa Boro, New Jersey			
24. FUNERAL DIRECTOR Jas. T. Ryan, Inc. ADDRESS 317 Pa. Ave., SE DC3					25a. REC'D BY REGISTRAR APR 7 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 45 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY Parlin c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 318 Ernston Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Thomas John Ambrosio			4. DATE OF DEATH April 13 1966		5. SEX Male			6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 19 August 1963		9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR (If under 24 HRS. Months Days Hours Min.)		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME Severino J. Ambrosio			14. MOTHER'S MAIDEN NAME Lillian O'Brien						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFIRMARY The Medical Records The Clinical Center, Bethesda, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 3442 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hydrocephalus and cerebral atrophy DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aminoaciduria								INTERVAL BETWEEN ONSET AND DEATH 12 hours 2 1/2 years	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that MD (this hospital) attended the deceased from February 27, 1966 , to April 13, 1966 , that MD (we) last saw the deceased alive on April 13, 1966 , and that death occurred at 6:45 M. from the causes and on the date stated above.									
22a. SIGNATURE William D. Heizer			22b. DATE SIGNED 13 April 1966		22c. PHYSICIAN'S NAME (Type) William D. Heizer, M.D.				
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.			22e. REC'D BY REGISTRAR APR 14 1966						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - tranist 4/13/66			23b. DATE THEREOF Gate of Heaven Cem.		23c. NAME OF CEMETERY OR CREMATORY Hanover, New Jersey		23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR Robert A. Pumphrey			24a. ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE J. Charles Judge				

VR AIS (4)
20M 1/65

05446

05440

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Virginia</i> b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>19 days</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Richmond</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington San. & Hospital</i>				e. STREET ADDRESS <i>4709 Caldwell Ave</i>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>Bertie</i>		Middle <i>Mac</i>	Last <i>Anderson</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>8/22/87</i>		9. AGE (In years last birthday) <i>78 yrs.</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Oays Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired CITY EMPLOYEE</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Kentucky</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Isaac L. Hughes</i>		14. MOTHER'S MAIDEN NAME <i>Mundy, ELLEN</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>301-07-9122</i>		17. INFORMANT Address <i>Wash San & Hosp Records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i> DU TO (b) <i>Generalized Arteriosclerosis</i> CAUSE (c) <i>Obstruction of Duodenum</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from April 18, 1966, to April 30, 1966, that (I) (we) last saw the deceased alive on April 30, 1966, and that death occurred at 6 P.M. from the causes and on the date stated above.					
22a. SIGNATURE <i>Lyle Williams</i>		22b. DATE SIGNED <i>April 30, 1966</i>		22c. PHYSICIAN'S NAME (Type) <i>Lyle Williams</i>	
22d. ATTENDING PHYS. M.D. <input checked="" type="checkbox"/> MEQ. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22e. ADDRESS <i>831 University Blvd E Silver Spring Md</i>			
23a. BURIAL CREMATION REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>5-1-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>MAURY CEM.</i>	
23d. LOCATION (City, town or county) (State) <i>Richmond, VIRGINIA</i>					
24. FUNERAL DIRECTOR <i>Joseph W. Blakey</i>		ADDRESS <i>Richmond, Va.</i>		25a. REC'D BY REGISTRAR <i>John C. Thomas</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>MAY 3 1966</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05447		05447	
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
c. LENGTH OF STAY IN 1b 5 days		d. STREET ADDRESS 1505 CONSTANCE ST	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOLY CROSS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES Edward ANDERSON		4. DATE OF DEATH Month Day Year APRIL 16 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/24/18
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER Jimmie's DELICATESSEN		11. BIRTHPLACE (County & State, or foreign country) D.C.	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Letcher Caleb Anderson		14. MOTHER'S MAIDEN NAME Mary McClosky	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-34-6112	
17. INFORMANT Madeline J. Anderson		Address 1505 Constance Street, Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO PULMONARY EDEMA CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST, (c) CHEST DEFORMITIES PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) KYPHOSCOLIOSIS & SPINAL DEFORMITY			INTERVAL BETWEEN ONSET AND DEATH 7 DAYS YEARS
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 3, 1964 , to April 16, 1966 , that (I) (we) last saw the deceased alive on April 16, 1966 , and that death occurred at 11:54 AM , from the causes and on the date stated above.			
22a. SIGNATURE Charles Farwell		22b. DATE SIGNED 4/18/66	
22c. PHYSICIAN'S NAME (Type) Charles Farwell, M.D.		22d. ADDRESS 11406 Viers Mill Rd., Wheaton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 20 April 1966	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	23d. LOCATION (City, town or county) (State) Silver Spring, Maryland
24. FUNERAL DIRECTOR Charles E. Purphrey, Inc.		25a. REC'D BY REGISTRAR APR 21 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION



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Cleared by the Registrar

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 1803 Everest Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Margaret		First Margaret		Middle NMI		Last Anselmo		4. DATE OF DEATH Month April Day 26 Year 1966		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 4, 1905		9. AGE (In years last birthday) 60 yrs. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joseph Cosimano					14. MOTHER'S MAIDEN NAME Anna Geraci					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-24-6989		17. INFORMANT Daughter Anna M. Anselmo,		Address 1803 Everest St. Silver Spring, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aortic stenosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 110X DUE TO (b) Mitral stenosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 										INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7/21 , 19 64 , to 4/26 , 19 66 , that (I) (we) last saw the deceased alive on March 17 , 19 66 , and that death occurred at 6:11 AM , from the causes and on the date stated above.										
22a. SIGNATURE [Signature]				22b. DATE SIGNED 4/28/1966						
22c. PHYSICIAN'S NAME (Type) Barton J. Gershen				22d. ADDRESS 50 W. Edmanston Dr., Rockville, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 29 April 1966		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City, town or county) (State) Silver Spring, Maryland				
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc Address 2434 Georgia Avenue Silver Spring, Md.						25a. REC'D BY REGISTRAR MAY 2 1966		25b. REGISTRAR'S SIGNATURE [Signature]		

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN ID <u>3 weeks</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				d. STREET ADDRESS <u>1915 Fox Street</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Kenneth</u> First <u>Engene Ardinger</u> Middle <u>Arndinger</u> Last		4. DATE OF DEATH <u>4</u> Month <u>10</u> Day <u>19</u> Year <u>66</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 28, 1895</u>		9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Investigator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Calvert Loan Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Williamsport Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>James Eugene Ardinger</u>		14. MOTHER'S MAIDEN NAME <u>Ida Patton</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>578-05-9196</u>		17. INFORMANT <u>Mrs. Thelma Devault</u>		Address <u>1915 Fox St. Hyattsville, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral artery inf</u> 1634 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1634</u> DUE TO (c) <u>1634</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1634</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1963</u> , to <u>Apr 10, 1966</u> , that (I) (we) last saw the deceased alive on <u>Apr 9, 1966</u> , and that death occurred at <u>2:10 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Philip H. Varner</u>		22b. DATE SIGNED <u>4-10-66</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		M.O. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) <u>Philip H. Varner</u>		22d. ADDRESS <u>10620 Georgia Ave., S. S., Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>14 April 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>					
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05450

05450

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY:	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie	
c. LENGTH OF STAY IN TB 36 days		d. STREET ADDRESS 12625 Millstream Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Nancy Pettry Arnett		4. DATE OF DEATH April 7 1966	
5 SEX Female	6. COLOR OR RACE Caucasian	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 21 Feb. 1935
9 AGE (In years last birthday) 31 yrs		IF UNDER 1 YEAR Months 1 Days 16 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher		10b. KIND OF BUSINESS OR INDUSTRY Education	
11. BIRTHPLACE (County & State, or foreign country) Packsville, W. Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Dewey Pettry		14. MOTHER'S MAIDEN NAME Icic Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 234-56-8121	
17. INFORMANT Alvin Arnett, Bowie, Maryland		12625 Millstream Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia DUE TO (b) Metastatic leiomyosarcoma DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 2 y
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 2 , 19 66 to April 7 , 19 66 , that (I) (we) last saw the deceased alive on April 7 , 19 66 , and that death occurred at 3:18 P M, from causes and on the date stated above			
22a. SIGNATURE <i>R. B. Mottin</i>		22b. DATE SIGNED April 8, 1966	
22c. PHYSICIAN'S NAME (Type) R. B. Mottin, M. D.		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 4-8-66	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Family Cemetery (no name)	23d. LOCATION (City or Town) (County) (State) Raleigh County, W. Virginia
24. FUNERAL DIRECTOR R. A. Pumphrey Funeral Home		25. RECEIVED BY REGISTRAR APR 11 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

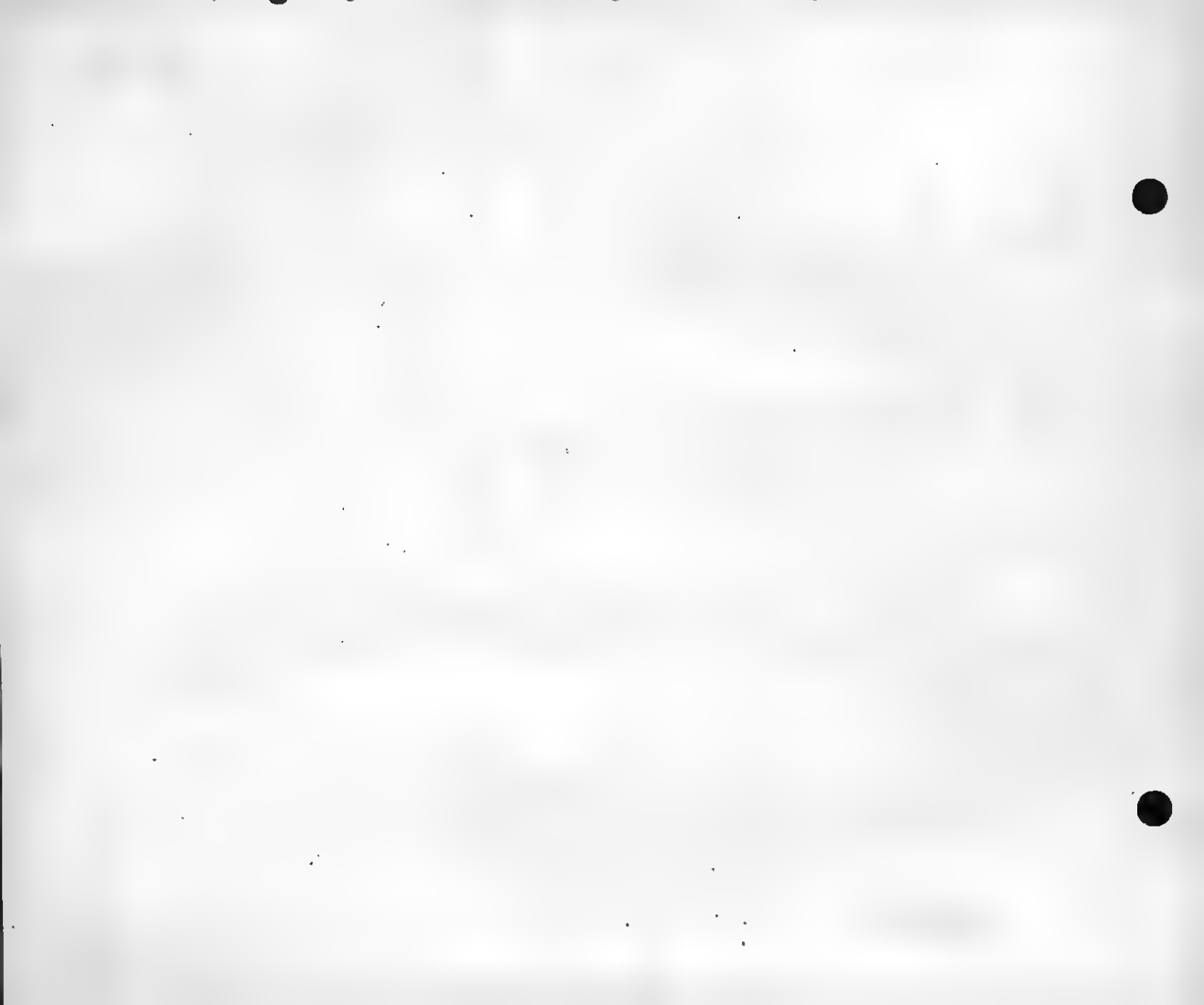


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05451											
1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>MONTGOMERY</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i>						c. LENGTH OF STAY IN 1b <i>10 days</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Holy Cross Hosp.</i>						d. STREET ADDRESS <i>203 East Schuyler</i>					
3. NAME OF DECEASED (Type or print) First <i>Gus</i> Middle <i>J.</i> Last <i>Babest</i>						4. DATE OF DEATH Month <i>4</i> Day <i>10</i> Year <i>1966</i>					
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10/16/84</i>		9. AGE (In years last birthday) <i>81</i> yrs.		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>restaurant business</i>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>GREECE</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Babest</i>						14. MOTHER'S MAIDEN NAME <i>Stmata Retsinas</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO. <i>222-09-7966</i>		17. INFORMANT <i>Louis Babest</i>		Address <i>same as #2</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetic Renal Disease</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Diabetes mellitus</i>											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerotic Cardiovascular Disease</i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 1960</i> to <i>4/10</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>4/10</i> 19 <i>66</i> , and that death occurred at <i>11:45 P</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Blaine H. Eig</i>						22b. DATE SIGNED <i>4/11/66</i>					
22c. PHYSICIAN'S NAME (Type) <i>Blaine H. Eig</i>						22d. ADDRESS <i>8641 Colasville Road, Silver Spring</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>				23b. DATE THEREOF <i>4/13/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Prince Georges County, Md</i>			
24. FUNERAL DIRECTOR <i>The S. H. Hines Co.</i>				ADDRESS <i>2901-14 St. N.W.</i>		25a. REC'D BY REGISTRAR <i>APR 12 1966</i>		25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>			



05452

CERTIFICATE OF DEATH

05452

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>5908 Rolston Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Harriet</u> First <u>A</u> Middle <u>Babington</u> Last		4. DATE OF DEATH <u>4-23-</u> Day Year <u>66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/28/1878</u>
9. AGE (In years last birthday) <u>87</u> yrs		10. IF UNDER 1 YEAR Months Days 19 <u>66</u> Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland - Montgomery</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Thomas Levier</u>		14. MOTHER'S MAIDEN NAME <u>Anna Trundle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>- - -</u>	
17. INFORMANT <u>Daughter - Anna Babington</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Arteriosclerotic gangrene right leg</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>arteriosclerotic gangrene right leg</u> DUE TO (c) <u>3 mo</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>urinary failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-19-66</u> to <u>4-23-</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>1:00 P.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John O. Robben</u> M.D.		22b. DATE SIGNED <u>4-23-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John O. Robben M.D.</u>		22d. ADDRESS <u>10511 SUMMIT AVE, KENSINGTON, MD-</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-27-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Bethesda, Maryland</u>	
24. FUNERAL DIRECTOR <u>Joe. Lawrence Sons Washington D.C.</u>		25a. REC'D BY REGISTRAR <u>APR 26 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05453

05453

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Washington, D. C. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 4716 47th Street N. W.			
3. NAME OF DECEASED (Type or print) First Harry Middle Willard Last Bailey				4. DATE OF DEATH Month April Day 16 Year 19 66			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 Jan. 1888	9. AGE (in years 1st birthday) yrs. 78	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy retired		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (County & State, or foreign country) Bristol, Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William R. Bailey				14. MOTHER'S MAIDEN NAME Margaret Curothers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO		17. INFORMANT Mrs. Anna M. Bailey Washington, D. C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 3, 19 66 , to April 16, 19 66 , that (I) (we) last saw the deceased alive on April 16, 19 66 , and that death occurred at 15 A.M. from causes and on the date stated above							
22a. SIGNATURE <i>James S. Shumaker</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 16 April 1966	
22c. PHYSICIAN'S NAME (Type) XXXXXX				22d. ADDRESS U. S. Naval Hospital Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Joseph Gawler & Son				5130 Wisconsin Avenue Washington, D. C.		25a. REC'D BY REGISTRAR APR 20 1966	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

05454

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05454

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>4 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>				d. STREET ADDRESS <u>9920 Moss Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>Thomas</u> Last <u>BAKER</u>				4. DATE OF DEATH <u>April 13th</u> 19 <u>66</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 16, '79</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>		IF UNDER 24 HRS. Months <u>8</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Builder & Contractor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>William Edwin BAKER</u>				14. MOTHER'S MAIDEN NAME <u>Kathryn Poole</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>578-16-7118</u>		17. INFORMANT <u>Rosalie B. Selby</u> Address: <u>9920 Moss Avenue Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>							
DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>							
DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CEREBRAL ARTERIOSCLEROSIS</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 1961</u> to <u>APRIL 13, 1966</u> , that (I) (we) last saw the deceased alive on <u>APRIL 11, 1966</u> and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas F O'Connor M.D.</u>				22b. DATE SIGNED <u>APRIL 13, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>TITOMAS F O'CONNOR M.D.</u>				22d. ADDRESS <u>8218 WISCONSIN AVE, BETHESDA, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>16 April 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln RXX Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince George Co. Md</u>	
24. FUNERAL DIRECTOR <u>Warner E. Purphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>J. Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

APR 18 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner - Ind.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN ID D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS Apt. 718 261 Congressional Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First CHARLEY Middle BARBER Last BARBER					4. DATE OF DEATH Month April Day 9 Year 1966				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/15/1895		9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor Inventory				10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov.		11. BIRTHPLACE (County & State, or foreign country) Mintonville, Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW I					16. SOCIAL SECURITY NO. 577-60-3580		17. INFORMANT Mrs. Marie P. Barber Address 261 Congressional La. Rockville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Unknown								INTERVAL BETWEEN ONSET AND DEATH Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 17, 1966 to April 2, 1966 , that (I) (we) last saw the deceased alive on April 2, 1966 , and that death occurred at 8 PM , from the causes and on the date stated above.									
22a. SIGNATURE Barton J. Gershen					22b. DATE SIGNED			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Barton J. Gershen					22d. ADDRESS 50 W. Edmanston Dr., Rockville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 13 April 1966		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.			23d. LOCATION (City, town or county) (State) Arlington, Va.		
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. ADDRESS 8434 Georgia Avenue Silver Spring, Md.					25a. REC'D BY REGISTRAR APR 13 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				c. LENGTH OF STAY IN 1b <i>2 WEEKS</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Holm Cross Hospital</i>					d. STREET ADDRESS <i>17100 Salt-lick Road</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Anna</i> Middle <i>Edna</i> Last <i>Barnett, SR.</i>					4. DATE OF DEATH Month <i>April</i> Day <i>23</i> Year <i>1966</i>						
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>August 8, 1890</i>		9. AGE (In years last birthday) <i>75</i> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Inspector</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>US Post Office Dept.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Kentucky</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>William H. Barnett</i>					14. MOTHER'S MAIDEN NAME <i>Margaret Johnson</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>					16. SOCIAL SECURITY NO. <i>577-52-7625</i>		17. INFORMANT <i>Mrs Margaret Kerns</i>			<i>1706-Hedger Road Rockville, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> 4 x 2 1/2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial Infarction</i> DUE TO (c) <i>Coronary Atherosclerosis</i>									INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>2 weeks</i> <i>Year</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from <i>April 19, 1966</i> to <i>April 23, 1966</i> that (I) (we) last saw the deceased alive on <i>April 19, 1966</i> and that death occurred at <i>3:4</i> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>John J. Curry</i>								22b. DATE SIGNED <i>4/23/66</i>			
22c. PHYSICIAN'S NAME (Type) <i>John J. Curry</i>								22d. ADDRESS <i>18650 Georgia Ave</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>April 26, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glenwood</i>			23d. LOCATION (City, town or county) (State) <i>Washington, DC</i>		
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>						ADDRESS <i>8434- Georgia Avenue Silver Spring, Md</i>		25a. REC'D BY REGISTRAR <i>APR 27 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05457									
CERTIFICATE OF DEATH									
Items 9-16 Film 3326 3/25/66 mh									
1. PLACE OF DEATH a. COUNTY <i>Montgomery Co</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Montgomery</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. LENGTH OF STAY IN 1b <i>1 yr - 1 mo - 1 day</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase, Md</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Gardens Sanatorium</i>				d. STREET ADDRESS <i>1405 FARRELL DRIVE</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Joseph</i>		Middle <i>BASMAN</i>		Last <i>BASMAN</i>		4. DATE OF DEATH Month <i>4</i>		Day <i>21</i>	
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>WHITE</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-12-1882</i>		9. AGE (In years last birthday) <i>83 91</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>?</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>MORRIS BASMAN</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>32-34-5115</i>		17. INFORMANT <i>Mrs Gordon</i>			
				Address <i>Chevy Chase, Md.</i> <i>8405 FARRELL DRIVE</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Insufficiency</i> DUE TO (b) <i>Cerebral Vascular Accident</i> DUE TO (c) <i>Pulmonary Emphysema</i>								INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>3 1/2 mo</i> <i>10 + YRS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Cerebral Arteriosclerosis; Arteriosclerotic Heart Disease</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Feb</i> , 1952 to <i>April</i> , 1966 that (I) <i>the</i> last saw the deceased alive on <i>4-20-1966</i> and that death occurred at <i>12 AM</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>Francis J. Murray</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4-21-66</i>			
22c. PHYSICIAN'S NAME (Type) <i>Francis J. Murray</i>				22d. ADDRESS <i>1601 18th St NW</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>4-21-1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>-</i>		23d. LOCATION (City, town or county) (State) <i>Charleston, W. Va.</i>			
24. FUNERAL DIRECTOR <i>Joseph Lawler's Sons, Inc.</i>				ADDRESS <i>5130 Wisc. Ave. N.W. Wash. DC.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
				DATE <i>APR 25 1966</i>					

CERTIFICATE OF DEATH

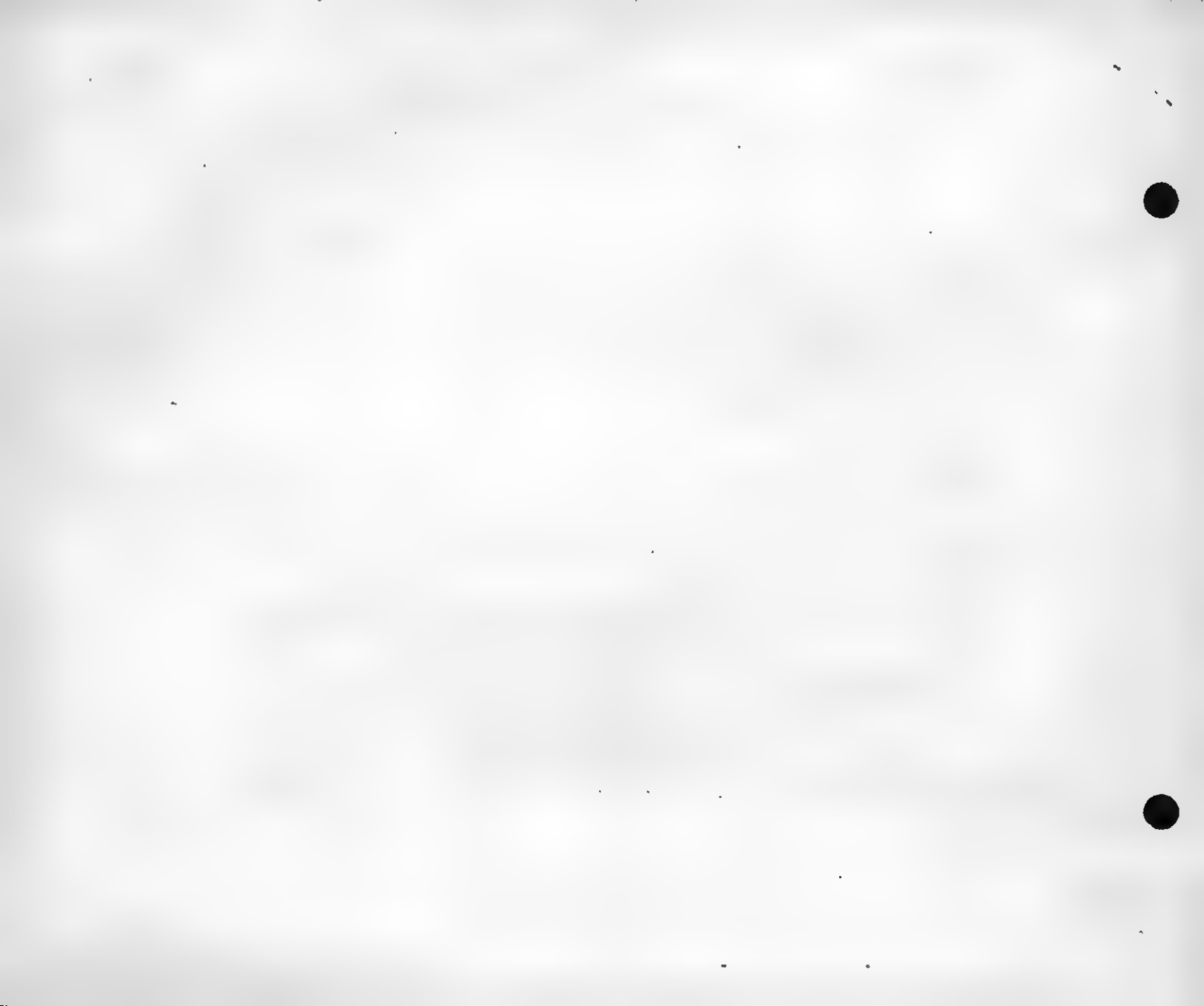
05458

05458

1 PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Rockville, Md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>		d. STREET ADDRESS <u>203 Croydon Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Fred Leo Baugh</u>		4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/10/1893</u>
9 AGE (in years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>11</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Draftsman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Ellettsville, Indiana</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>CHARLES BAUGH</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. James Delia EAKIN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>307-10-6476</u>	
17. INFORMANT <u>Mrs. James Woods</u>		Address <u>714 Beall Ave Rockville, Md</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCH PNEUMONIA</u> DUE TO <u>332x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>CEREBRAL ENCEPHALOMALACIA</u> DUE TO <u>6 WEEK</u> (c) <u>ESSENTIAL HYPERTENSION</u> <u>10 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAY</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>61</u> to <u>April 21</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>APRIL 21</u> , 19 <u>66</u> , and that death occurred at <u>11:41 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>William Frank</u>		22b. DATE SIGNED <u>April 21, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM FRANK</u>		22d. ADDRESS <u>11125 ROCKVILLE PIKE, ROCKVILLE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-25-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>
24 FUNERAL DIRECTOR <u>Robert A. Pumphrey,</u>		25a. REC'D BY REGISTRAR <u>APR 26 1966</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or any other event, within 72 hours after death.



05459

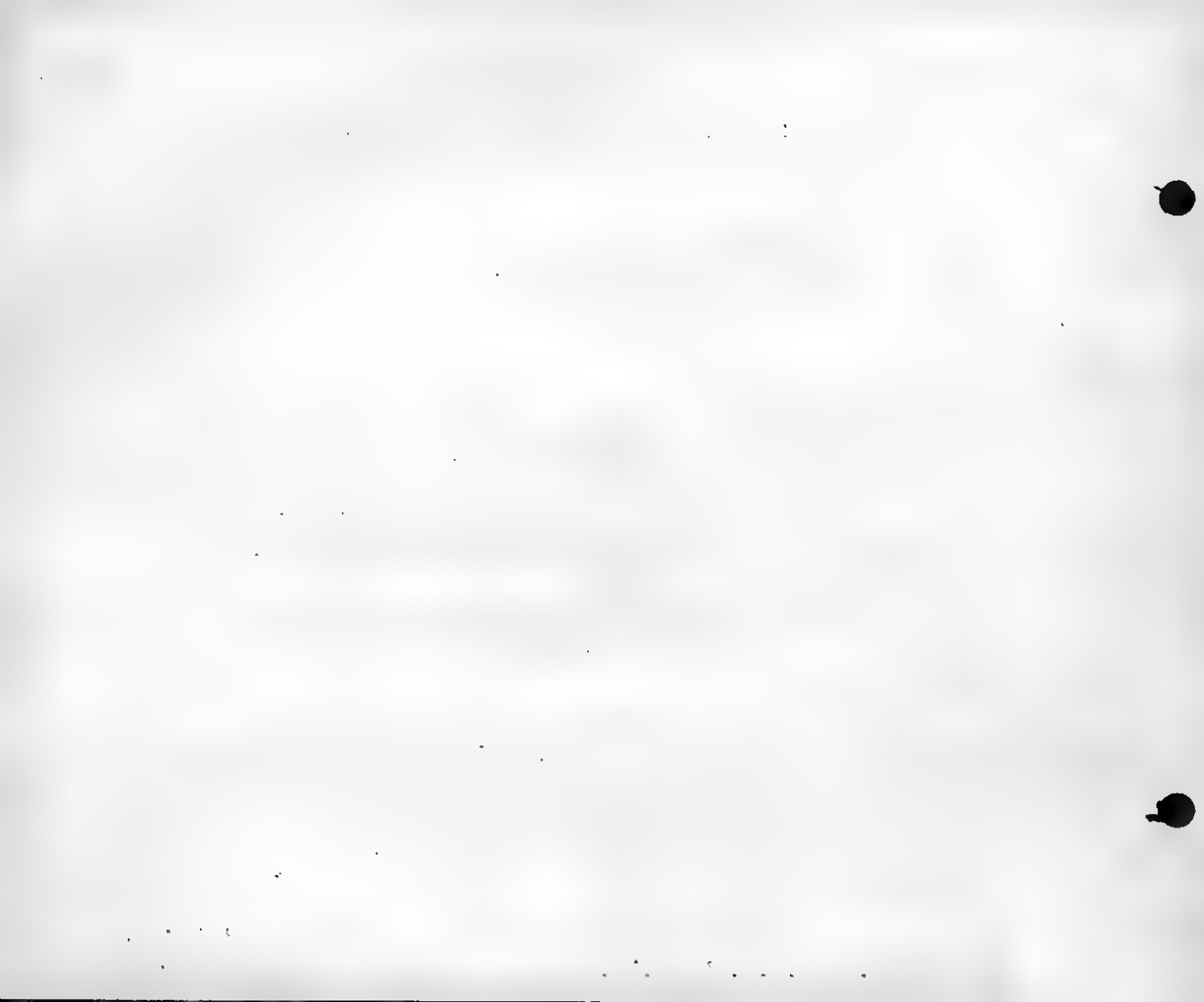
CERTIFICATE OF DEATH

05459

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
c. LENGTH OF STAY IN 1b <u>10 days</u>		d. STREET ADDRESS <u>7107 EXFAIR RD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LELAND</u> Middle <u>R</u> Last <u>BECKWITH</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>24</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-14-1902</u>
9. AGE (n years last birthday) <u>63</u> yrs		10. IF UNDER 1 YEAR Months <u>24</u> Days <u>24</u> Hours <u>00</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Photo Engraver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Buffalo, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>NEWELL F. BECKWITH</u>		14. MOTHER'S MAIDEN NAME <u>HELEN FULLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-03-1186</u>	
17. INFORMANT <u>Genevieve Beckwith - wife</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>1 year</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertensive vascular disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 14</u> , 19 <u>66</u> , to <u>April 24</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>April 24</u> , 19 <u>66</u> , and that death occurred at <u>7:25</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Robert N. Coale</u>		22b. DATE SIGNED <u>April 24, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>		22d. ADDRESS <u>4429 Bradley Lane Chevy Chase, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-27-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u>
24. FUNERAL DIRECTOR <u>Joseph Cawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
24. ADDRESS <u>5130 Wise Ave. N.W. Wash. DC.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05460

05460

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>1 yr. 8 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hill Haven Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>XXXXXX. D. C.</u> b. COUNTY <u>Washington, D. C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u> d. STREET ADDRESS <u>3720 Benton St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <u>GRACE</u> First Middle Last <u>Wilson BEELMAN</u>				4. DATE OF DEATH Month Day Year <u>April 24 19 66</u>													
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 10, 1876</u>		9. AGE (In years last birthday) <u>89</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.																
Months	Days																
	Hours																
	Min.																
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Music Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Private Music</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Plymouth, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>									
13. FATHER'S NAME <u>J. Franklin Beelman</u>				14. MOTHER'S MAIDEN NAME <u>Francelia Gipson</u>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT Address <u>Mrs. Mary E. Ambrose 4305 Van Buren St. Hyattsville, Md.</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td style="padding: 5px;"> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u> </td> <td style="padding: 5px;"> INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u> <u>3-4 days</u> </td> </tr> </table>										PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>	INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u> <u>3-4 days</u>				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>	INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u> <u>3-4 days</u>														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Bronchitis</u>																	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>2/5</u> , 19 <u>65</u> to <u>4/24</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Apr 23</u> , 19 <u>66</u> , and that death occurred at <u>8:50 PM</u> , from the causes and on the date stated above.																	
22a. SIGNATURE <u>(Signature)</u>				22b. DATE SIGNED <u>4-24-66</u>				22c. PHYSICIAN'S NAME (Type) <u>RAYMOND E. WEST M.D.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>28 April 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Plymouth, Ohio</u>									
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>(Signature)</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05461						05461					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
Montgomery			Silver Spring			Maryland			Montgomery		
c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
			Residence			214 University Blvd.			West		
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last						Month Day Year					
Carl Louis Remies						April 9- 1966					
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IS RESIDENCE ON A FARM?	
M		W		NEVER MARRIED		July 24-1892		73 yrs.		YES <input type="checkbox"/> NO <input type="checkbox"/>	
WIDOWED		DIVORCED									
11. BIRTHPLACE (County & State, or foreign country)						12. CITIZEN OF WHAT COUNTRY?					
Insurance Inspector, Tyne, Ohio, Progress, Panama.											
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Charles Otis Damico						Caroline					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
								Mrs Margaret N. Damico		214 University Blvd. W. Apt.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE: (a) Carcinoma of liver & widespread											
DUE TO (b) metastases, hemorrhage, cardiac											
DUE TO (c) failure											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year											
Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Jan 1961, to April 9, 1966, that (I) (we) last saw the deceased alive on 9 April 1966, and that death occurred at 8 P.M. from the causes and on the date stated above.											
22a. SIGNATURE											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type)											
22d. ADDRESS											
22e. MED. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
23a. BURIAL CREMATION REMOVAL (Specify)											
23b. DATE THEREOF											
23c. NAME OF CEMETERY OR CREMATORY											
23d. LOCATION (City, town or county) (State)											
24. FUNERAL DIRECTOR											
25a. RECD BY REGISTRAR											
25b. REGISTRAR'S SIGNATURE											
April 12-1966						Fork Luicoff			Baltimore-Land Md.		
Arthur Valters						254 Carroll St			APR 13 1966		
									Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please prepare carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05462 CERTIFICATE OF DEATH 05462											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>						c. LENGTH OF STAY IN 1b <u>4 months</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4316 Valley Stream Avenue</u>						d. STREET ADDRESS <u>808 Hollywood Avenue</u>					
3. NAME OF DECEASED (Type or print) <u>Ottie Blanche Bennett</u>						4. DATE OF DEATH <u>April 29 1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 13, 1883</u>		9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>UNKNOWN</u>						14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Ethel B. Cribbs</u> Address <u>4316 Valley Stream Ave. Burtonsville, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>443x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>5+ years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> to <u>April 29, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 13 1966</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>John N. Andrews</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-29-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>						22d. ADDRESS <u>9601 Colesville Rd Silver Spring Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 2, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince George, Md.</u>					
24. FUNERAL DIRECTOR <u>John P. Skoncos</u>		ADDRESS <u>8434 Georgia Avenue</u>		25. REC'D BY REGISTRAR <u>MAY 5 1966</u>		25b. REGISTRAR'S SIGNATURE <u>John P. Skoncos</u>					
Warner E. Pumphrey, Inc. Silver Spring, Md.											

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. CITY Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8103 Eastern Avenue		e. STREET ADDRESS 8103 Eastern Avenue	
3. NAME OF DECEASED (Type or print) Jennie First name Middle Berkowitz Last		4. DATE OF DEATH Month 4 Day 5 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/15/1892
9. AGE (in years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 1 Days 10 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Son- Maurice Berk		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO (b) Atherosclerotic Heart Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
SIGNATURE Belden R. Reap, M.D.		22. DATE SIGNED April 6, 1966		
EXAMINER'S NAME (Type) Belden R. Reap, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-8-66	23c. NAME OF CEMETERY OR CREMATORY WASH HEBERLEIGH CEM.	23d. LOCATION (City, town or county) (State) WASHINGTON D.C.	
24. FUNERAL DIRECTOR GOLDBERG FUNERAL HOME		25a. REC'D BY REGISTRAR APR 11 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



4 1 M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

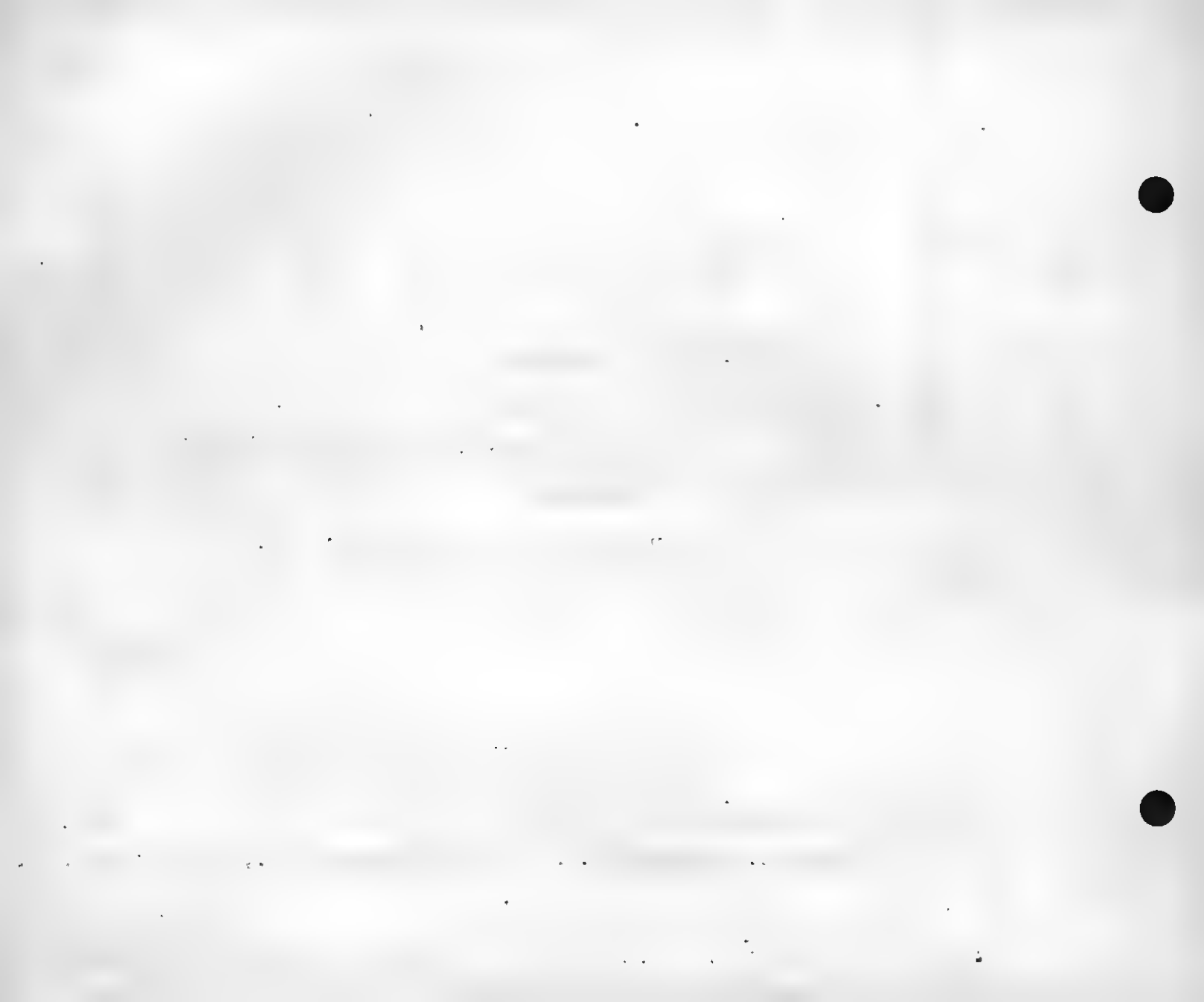
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05464

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05464

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 23 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOLY CROSS HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 1310 Noyes Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LOUISE S BIRDELL		4. DATE OF DEATH Month Day Year 4 6 1966	
5. SEX F	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/14/02
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 63	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE - OWN HOME		10b. KIND OF BUSINESS OR INDUSTRY D.C.	
11. BIRTHPLACE (County & State, or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Ralph A. Shepard		14. MOTHER'S MAIDEN NAME Corena Randsdall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Wayne Birdsell		Address 1310 Noyes Drive Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Scleroderma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Pulmonary abscess right upper lobe. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-15, 1965 , to 4-6, 1966 , that (I) (we) last saw the deceased alive on 4-6, 1966 , and that death occurred at 6:40 PM , from the causes and on the date stated above.			
22a. SIGNATURE George F. Sengstack M.D.		22b. DATE SIGNED 4-7-66	
22c. PHYSICIAN'S NAME (Type) George F. Sengstack, M.D.		22d. ADDRESS 9241 Columbia Blvd., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9 April 1966	
23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City, town or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR APR 11 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05465 CERTIFICATE OF DEATH 05465											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY IN 1b <u>15 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery General Hospital.</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> d. STREET ADDRESS <u>439 N. Frederick Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>RUTH</u> First <u>A</u> Middle <u>BIRNBAUM</u> Last 4. DATE OF DEATH <u>4</u> Month <u>15</u> Day <u>19</u> Year <u>66</u>						5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>7/24/93</u> 9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>New York</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						13. FATHER'S NAME <u>Louis Baer</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth Altman</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>266-22-0567</u> 17. INFORMANT <u>Hospital records</u> Address <u>Olney, Maryland</u>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Coronary Thrombosis</u> (c) <u>Myocardial Infarction</u> <u>A.H.D. - Congestive Heart</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Tracheo-Bronchitis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u> 20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						21. I certify that (I) (this hospital) attended the deceased from <u>4/3/</u> , 19 <u>66</u> , to <u>4/15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/15</u> , 19 <u>66</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>Jack Schumacher</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <u> </u> 22d. ADDRESS <u> </u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/19/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Hebrew</u> 23d. LOCATION (City, town or county) (State) <u>Richmond, Va.</u>						24. FUNERAL DIRECTOR <u>Jos. W. Bliley Co. Richmond, Va.</u> 25a. REC'D BY REGISTRAR <u>APR 19 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>					

279 37



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

<div> <div>Items 10-21 Film G577 8-5770-11</div> <div>05466</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>05466</div> </div>									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spencerville				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital					d. STREET ADDRESS 16401 Batson Rd.				
3. NAME OF DECEASED (Type or print) First Laura Middle V. Last Bishop					4. DATE OF DEATH Month April Day 12 Year 1966				
5. SEX Female		6. COLOR OR RACE negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-11-1904		AGE (In years last birthday) 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Bowen					14. MOTHER'S MAIDEN NAME Daisy Boston				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO.		17. INFORMANT Officer J. E. McGoldrick		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive subarachnoid hemorrhage due to DUE TO (b) ruptured intracranial aneurysm. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, off. c. bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE Belden R. Reap M. D.			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22. DATE SIGNED 4-12-66
EXAMINER'S NAME (Type) Belden R. Reap M. D.			Address (Street, city, town, or county) Wheaton, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-15-66		23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery,		23d. LOCATION (City, town or county) (State) Ashton, Md.			
24. FUNERAL DIRECTOR Robert L. Surwode					ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR APR 15 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

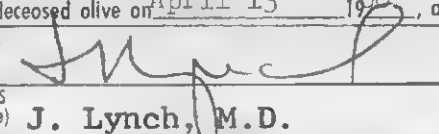
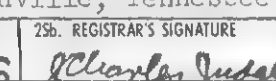
CERTIFICATE OF DEATH

05467

05467

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE North Carolina b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN IL 17 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. STREET ADDRESS 720 Barns Street	
3. NAME OF DECEASED (Type or print) First Robert Middle William Last Blakely		4. DATE OF DEATH Month April Day 13 Year 1966	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1966
9. AGE (In years last birthday) yrs. 31		IF UNDER 1 YEAR Months 31 Days 13 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ronald M. Blakely		14. MOTHER'S MAIDEN NAME Mickey Alexander	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital records, USNH, Bethesda, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple congenital anomalies 7593 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from March 27, 1966 , to April 13, 1966 , that (2) (we) lost the deceased alive on April 13, 1966 , and that death occurred at 3:45 P.M. from causes on and on the date stated above			
22a. SIGNATURE 		22b. DATE SIGNED 14 April 1966	
22c. PHYSICIAN'S NAME (Type) J. Lynch, M.D.		22d. ADDRESS U. S. Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial -transit 4/15/66		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Nashville, Tennessee	
24. FUNERAL DIRECTOR R. A. Pumphrey Funeral Home, 7557 Wisconsin Aven., Bethesda, Maryland		25a. REC'D BY REGISTRAR APR 18 1966	
25b. REGISTRAR'S SIGNATURE 			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05468

CERTIFICATE OF DEATH

05468

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>251 1/2 E. Montgomery Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Edward</u> Last <u>Bolton</u>				4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1966</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 11, 1903</u>		9. AGE (In years last birthday) yrs <u>62</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland - Montgomery</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Edward Bolton</u>				14. MOTHER'S MAIDEN NAME <u>Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>158 Holden Drive</u> Address <u>Manassas, Virginia</u> <u>Bernice Duwall</u> daughter			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary insufficiency</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis, severe</u> DUE TO (c) <u>years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Carcinoma, tongue & massive bleeding.</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 10, 1966</u> to <u>April 16, 1966</u> that (I, we) last saw the deceased alive on <u>April 16, 1966</u> and that death occurred at <u>12</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Robert G. Pumphrey M.D.</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>4-16-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT G. PUMPHREY</u>				22d. ADDRESS <u>8505 Old Georgetown Rd Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/19/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Potomac Meth. Church Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Potomac, Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey Bethesda, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Bernice Duwall</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

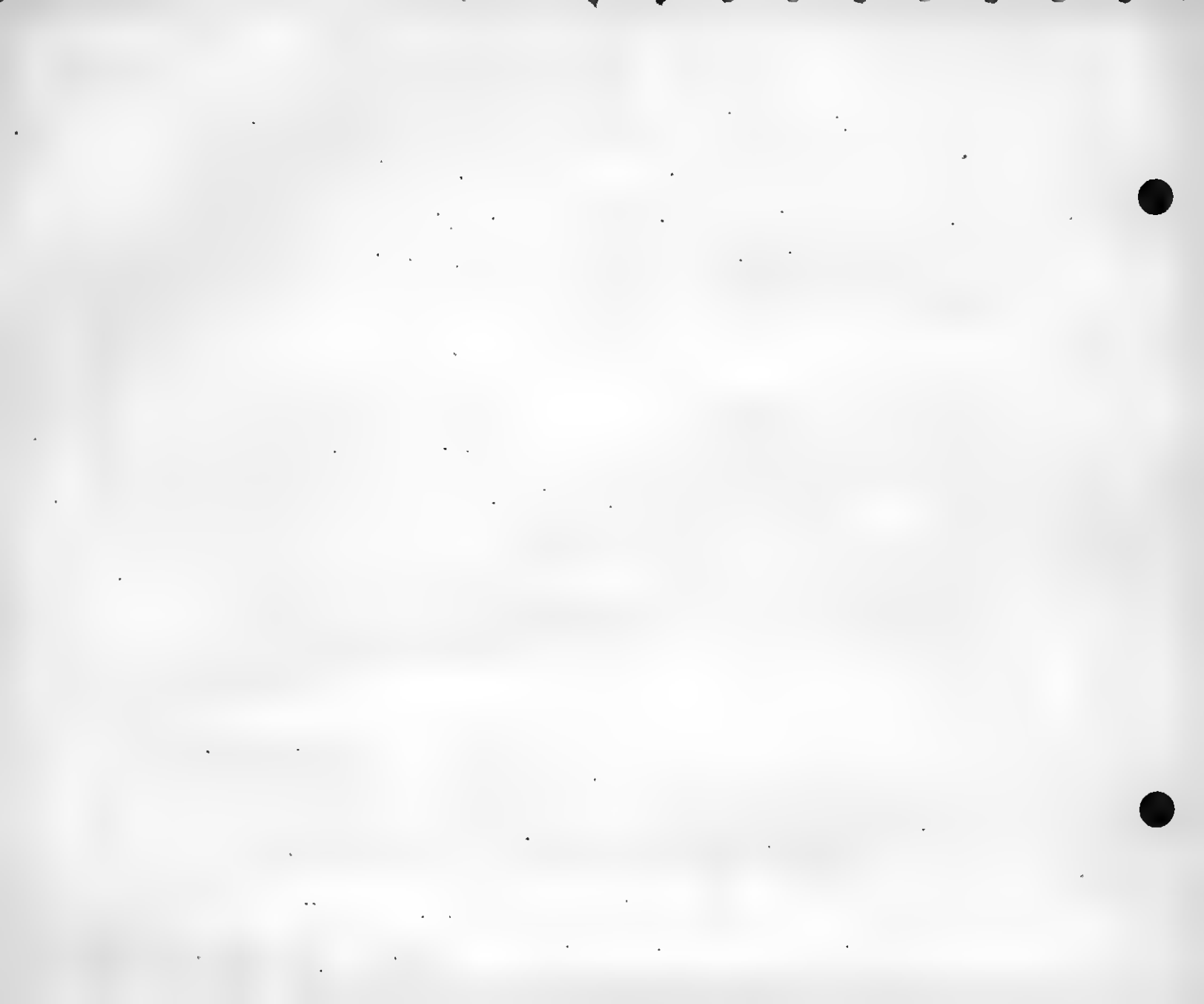
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
05469		05469							
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN b 1					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 705 Buckingham Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Nellie May Boss					4. DATE OF DEATH Month April Day 11 Year 1966				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-15-1889		9. AGE (in years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Brown					14. MOTHER'S MAIDEN NAME Lucy Hanback				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Mrs. Mildred Bender (See Item #2)			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic Coma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Carcinoma of Pancreas with metastases DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH 5 days 10 months
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Oct. 14, 1965 to April 11, 1966 , that (I) (we) last saw the deceased alive on 4/10 19 65 , and that death occurred at 7:30 PM from the causes and on the date stated above.									
22a. SIGNATURE Benjamin Isaacson					22b. DATE SIGNED 4/11/66				
22c. PHYSICIAN'S NAME (Type) Dr. Benjamin Isaacson					22d. ADDRESS 2733 ALASKA AVE. N.W. WASH. D.C.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-14-1966		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			23d. LOCATION (City, town or county) (State) Prince Georges Co. Md.		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 130 Wisc. Ave., Ave. N.W. Wash. D.C.					25a. REC'D BY REGISTRAR APR 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN ID <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH SANT & HOSPT</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> d. STREET ADDRESS <u>6109 EASTERN AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>CORA MAE BOWEN</u>						4. DATE OF DEATH Month Day Year <u>4-21-1966</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-31-1885</u>		9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>AUSTIN HUFF</u>						14. MOTHER'S MAIDEN NAME <u>SENA FARRELL</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>295-10-0907D</u>		17. INFORMANT <u>GLADYS M KRAUSS</u>			Address <u>SAME AS 2D</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Paralytic ileus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Surgical shock</u> DUE TO (c) <u>Fracture r. hip</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome, arteriosclerosis</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April 1966</u> , to <u>21 April 1966</u> , that (I) (we) last saw the deceased alive on <u>21 April 1966</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Joseph H. Cowan</u>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH H. COWAN M.D.</u>						22d. ADDRESS <u>4217 LINNEAN AV. N.W. WASH. 8 DC</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>4-25-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WASH NATL PARK CEM</u>			23d. LOCATION (City, town or county) (State) <u>Smithland Md</u>		
24. FUNERAL DIRECTOR <u>W.W. Chamber</u>						ADDRESS <u>8655 2nd Ave S.E. Hy Md.</u>		25a. REC'D BY REGISTRAR <u>APR 26 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

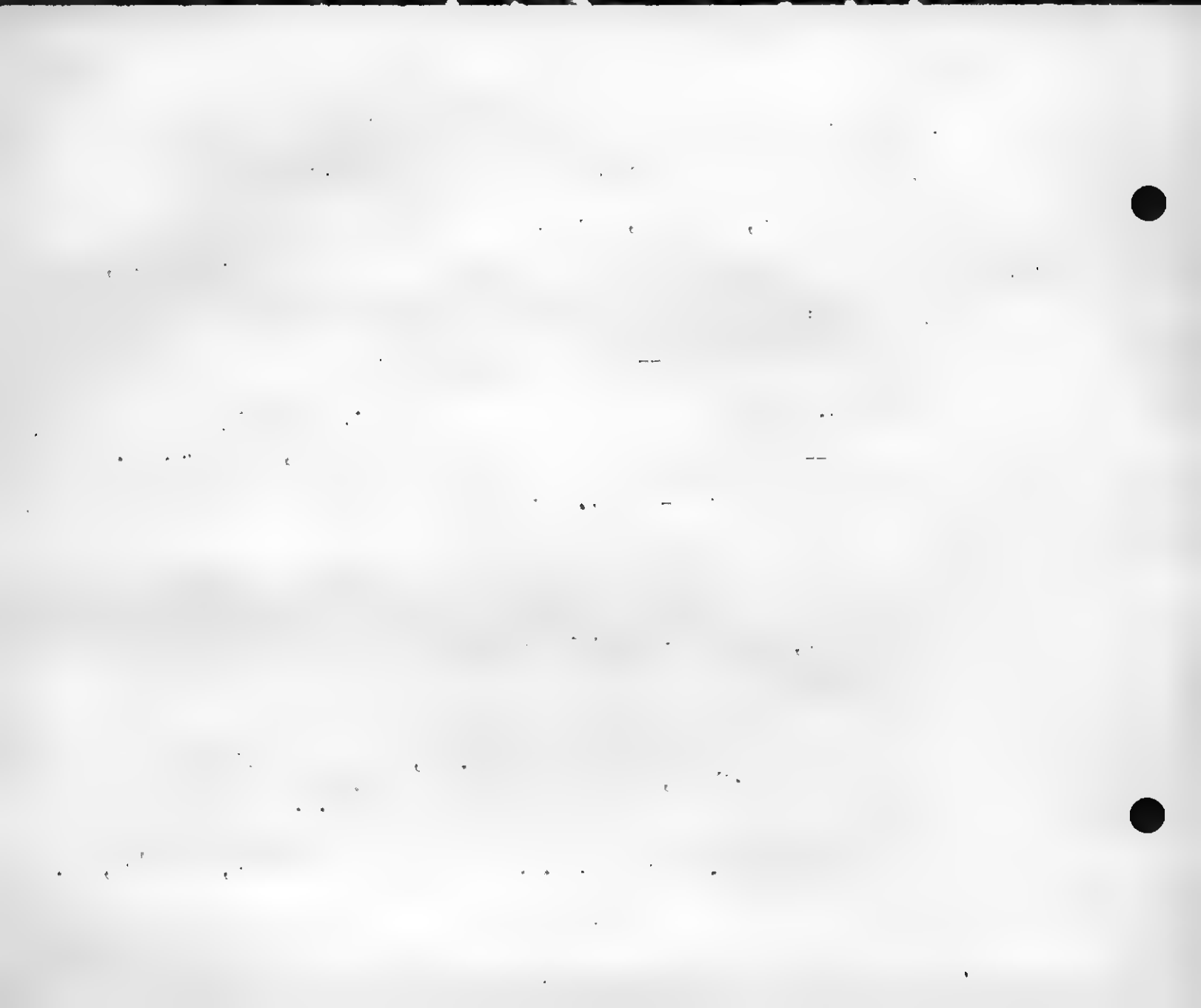


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
05471									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 58 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Shenandoah c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Seven Fountains d. STREET ADDRESS (None) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Larry Dean Boyer			4. DATE OF DEATH April 20, 1966		5. SEX Male				
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 September 1959		9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James D. Boyer					14. MOTHER'S MAIDEN NAME Wanda P. Coverstone				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record The Clinical Center, Bethesda, Md. 20014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram-negative septicemia 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Lymphocytic Leukemia DUE TO (c) ---								INTERVAL BETWEEN ONSET AND DEATH 18 hours 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia, probable Aspergillus - 1 month								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (D) (this hospital) attended the deceased from Feb. 21, 1966 , to April 20, 1966 , that (M) (we) last saw the deceased alive on April 20, 1966 , and that death occurred at 2:00M , from the causes and on the date stated above.									
22a. SIGNATURE Theodore S. Zimmerman					P.M. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 20 April 1966		
22c. PHYSICIAN'S NAME (Type) Theodore S. Zimmerman, M.D.					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4-23-66		23c. NAME OF CEMETERY OR CREMATORY Detrick Cem.		23d. LOCATION (City, town or county) (State) Seven Fountains, Va.		
24. FUNERAL DIRECTOR DELLINGER Funeral Homes, Inc. Bt - C. Dennis Herschman					ADDRESS Woodstock, VA		25a. REC'D BY REGISTRAR APR 25 1966		25b. REGISTRAR'S SIGNATURE Charles Judge



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
05472 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>North Chevy Chase</u> c. LENGTH OF STAY IN 1b <u>3 1/2 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bethesda-Silver Springs Nursing Home, N. Chevy Chase, Md.</u>					05472 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>Wilmington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wilmington</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>West</u> Last <u>Brinkley</u>			4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1966</u>		5. SEX <u>F</u>			6. COLOR OR RACE <u>W</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Jan 22, 1879</u>		9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) <u>Wilmington, N.C.</u>			12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13. FATHER'S NAME <u>ISAIAH WEST</u>					14. MOTHER'S MAIDEN NAME <u>MARY MAC DONALD</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>DAVID BRINKLEY - SON</u> Address <u>18 W. KIRK ST. CHEVY CHASE, MD</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral thrombosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 28, 1965</u> , to <u>April 10, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 8, 1966</u> , and that death occurred at <u>2:00 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Orville W. Donnelly</u>					22b. DATE SIGNED <u>April 19, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Orville W. Donnelly, MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					23b. DATE THEREOF <u>4-13-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DAKDALE CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>WILMINGTON, NORTH CAROLINA</u>		
24. FUNERAL DIRECTOR <u>JOS. GAWLER'S SONS, INC</u>					25a. REC'D BY REGISTRAR <u>APR 12 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



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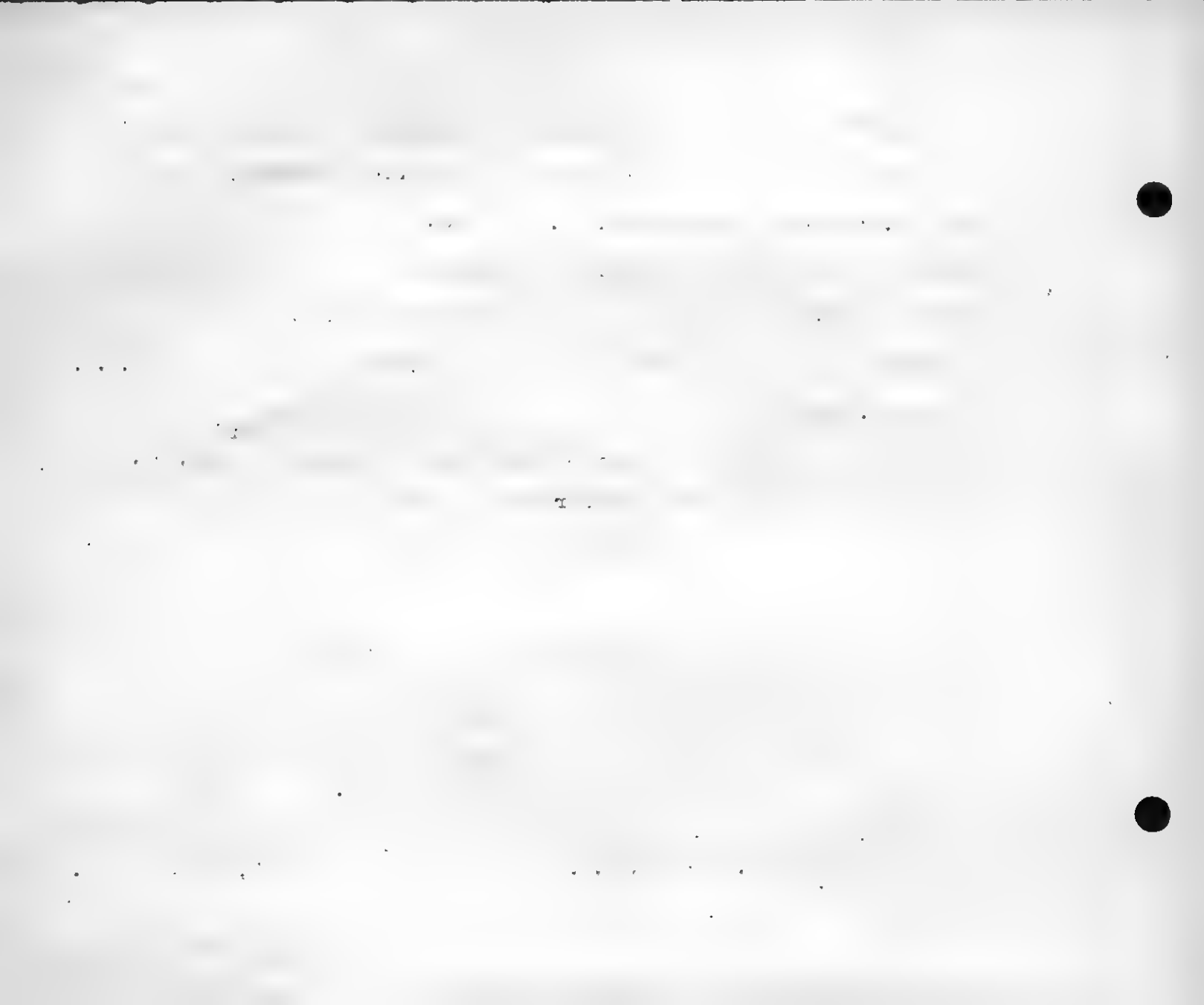
MONTGOMERY											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05473											
CERTIFICATE OF DEATH											
05473											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>7 YRS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3000 McComas Ave. Kensington Gardens Sanatorium</u>						d. STREET ADDRESS <u>1100 Michigan Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WANNIE D. BROWN</u>						4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 8 1875</u>		9. AGE (in years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months Days Hours Mins. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>William Diffenderfer</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Home Records</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>generalized arteriosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>10 yrs</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (if this hospital) attended the deceased from <u>April, 1957</u> to <u>April, 1966</u> , that (I) (we) last saw the deceased alive on <u>March 31, 1966</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/1/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>H F Kreuzburg</u>						22d. ADDRESS <u>7852 16th St N.W. Washington, D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>				23b. DATE THEREOF <u>4/5/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges County, Md</u>			
24. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u>						2901 14th St. N.W. <u>Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>APR 5 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>101 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Campbell</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rustburg</u> d. STREET ADDRESS <u>None</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Doris Pauline Bryant</u>			4. DATE OF DEATH <u>April 22 1966</u>			5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8 September 1912</u>		9. AGE (in years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Silas W. Smith</u>			14. MOTHER'S MAIDEN NAME <u>Amy Julia Newman</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>224-64-4737</u>			17. INFORMANT <u>The Medical Record</u> address <u>The Clinical Center, Bethesda, Md. 20014</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatty metamorphosis of liver</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myelogenous Leukemia</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>22 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that he (this hospital) attended the deceased from <u>January 11, 1966</u> , to <u>April 22, 1966</u> , that he (we) last saw the deceased alive on <u>April 22 1966</u> , and that death occurred at <u>7:40</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Wesley M. Vietzke</u>					22b. DATE SIGNED <u>23 April 1966</u>				
22c. PHYSICIAN'S NAME (Type) <u>Wesley M. Vietzke, M.D.</u>					22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>4/25/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evington Meth. Ch. Cae</u>		23d. LOCATION (city, town or county) (State) <u>Evington Va.</u>		
24. FUNERAL DIRECTOR <u>Whitten Funeral Home, Lynchburg, Va.</u>					25a. REC'D BY REGISTRAR <u>APR 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05475

05475

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY MONT.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 20 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) S.S.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1604 Carey La. Apt 340				d. STREET ADDRESS 1604 Carey La		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle EMIL Last BUNDRICK				4. DATE OF DEATH Month APRIL Day 21 Year 1966			
5. SEX male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-18-87	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 7 Days 18 Hours 15 Min.	IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) insurance salesman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Buffalo, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY BUNDRICK				14. MOTHER'S MAIDEN NAME SCHER Ernestine			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 133-10-8124		17. INFORMANT Elvira J. Bundrick		Address 1604 Carey La. S.S., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emphysema 5271 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DASHD, chr. CHF (2) Ca lung.						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-15, 1965 to 4-21, 1966 , that (I) (we) last saw the deceased alive on 4-21, 1966 , and that death occurred at 8:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE G. P. Sengstack M.D.				22b. DATE SIGNED 4-21-66		22c. PHYSICIAN'S NAME (Type) George P. Sengstack	
22d. ADDRESS 9741 Col. Blvd., S.S., Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/>		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 25 April, 1966		23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery		23d. LOCATION (City, town or county) (State) Rockville, N.H.	
24. FUNERAL DIRECTOR Robert B. Shum				25a. REC'D BY REGISTRAR APR 25 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05476

05476

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u> c. LENGTH OF STAY IN 1b <u>54 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> d. STREET ADDRESS <u>1700 North Roosevelt St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Henry</u> Last <u>BURCHETT</u>		4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Cauc</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 28, 1905</u>
9. AGE (in years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS: Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Navy</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Prestonsburg, Kentucky</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Wade Burchett</u>	
14. MOTHER'S MAIDEN NAME <u>Rosa Sizemore</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes 1924-1947</u>	
16 SOCIAL SECURITY NO. <u>06-38-1002</u>		17 INFORMANT <u>St. Arlington, Va.</u> <u>Mrs. Molly Z. Burchett, 1700 N. Roosevelt /</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: <u>Cerebral vascular accident</u> <u>331X</u> IMMEDIATE CAUSE (a) DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO _____ (c) DUE TO _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State) _____	
21. I certify that (H) (this hospital) attended the deceased from <u>Feb. 24</u> , 19 <u>66</u> , to <u>Apr. 19</u> , 19 <u>66</u> , that (H) (we) last saw the deceased alive on <u>Apr. 19</u> , 19 <u>66</u> , and that death occurred at <u>300A M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>W. L. Brannon</u>		22b. DATE SIGNED M.O. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>W. L. Brannon, M. D.</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-22-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>Ives Funeral Home</u> ADDRESS <u>2847 Wilson Blvd. Arlington, Va.</u>		25a. REC'D BY REGISTRAR <u>APR 25 1966</u> 25b. REGISTRAR'S SIGNATURE <u>John A. Judge</u>	

CERTIFICATE OF DEATH

05477

05477

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN IL <u>D.O.A</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>2616 Kensington Blvd.</u>	
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>FRANCES</u> Last <u>BURGESS</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>5</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 20 1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>Forest Glen MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CHARLES GASAWY</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT (husband) <u>NEIL BURGESS</u>		Address <u>2616 Kensington Blvd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 1. IMMEDIATE CAUSE (a) <u>poisoning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>poisoning metastatic</u> DUE TO (c) <u>poisoning metastatic</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 hrs</u> <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-15-1966</u> to <u>3-17-1966</u> that (I) (we) last saw the deceased alive on <u>3-17-1966</u> and that death occurred at <u>3-17-1966</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John C. Robben</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-5-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John C. Robben M.D.</u>		22d. ADDRESS <u>2616 Kensington Blvd Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>4/8/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>	23d. LOCATION (City or town) (County) (State) <u>Sandy Spring Montg. Md.</u>
24. FUNERAL DIRECTOR <u>George R. Snowden</u>		ADDRESS <u>Rockville</u>	25a. RECD BY REGISTRAR <u>APR 11 1966</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05478

CERTIFICATE OF DEATH

05478

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution, Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prs Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lokome Park Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park, Md</u>	
c. LENGTH OF STAY IN 1b <u>2 days</u>		d. STREET ADDRESS <u>5019 Nantucket Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>ANDREW</u> Last <u>BURR</u>		4. DATE OF DEATH Month <u>4</u> Day <u>20</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/18/66</u>
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>24</u> Months <u>24</u> Days <u>24</u> Hours <u>24</u> Min. <u>24</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James R. Burr</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Farrell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>James R. Burr</u>		Address <u>College Park, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRACRANIAL HEMORRHAGE</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 18, 1966</u> to <u>April 20, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 20, 1966</u> , and that death occurred at <u>9:55</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>		22b. DATE SIGNED <u>4-20-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>		22d. ADDRESS <u>217 UNIV. BLVD E, SILVER SP. MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/22/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lt Lincoln</u>		23d. LOCATION (City, town or county) (State) <u>Colmar Manor Md</u>	
24. FUNERAL DIRECTOR <u>F. Baschi sons Hyattsville Md</u>		25a. REC'D BY REGISTRAR <u>APR 25 1966</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05479		TUESDAY, APRIL 12, 1966						05479			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b <u>3 mos 2 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Congressional maver san.</u>						2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>3 Derbyshire Court</u>					
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>V.</u> Last <u>BUSCHER.</u>						4. DATE OF DEATH Month <u>APRIL</u> Day <u>4</u> Year <u>1966</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10 NOV 1885</u>		9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>James A. Love</u>		14. MOTHER'S MAIDEN NAME <u>Margaret A. Burck</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1's</u>		17. INFORMANT <u>Mrs Evelyn Foley</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>ARTERIO SCLEROTIC HEART DISEASE</u> (a), stating the underlying cause last. (c) <u>GENL ARTERIO SCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 MOS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (1) (this hospital) attended the deceased from <u>1955</u> to <u>PRESENT</u> , 19 <u>34</u> , that (1) (we) last saw the deceased alive on <u>3 April 1966</u> , and that death occurred at <u>3:40 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles E. Keegan Jr.</u>		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>3752 Benton St. NW Wash. DC 20007</u>		22b. DATE SIGNED		22e. REC'D BY REGISTRAR <u>APR 12 1966</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-7-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM. SUITLAND</u>		23d. LOCATION (City, town or county) (State) <u>MD.</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas B. Hanlon</u>		24b. ADDRESS <u>WASH D.C.</u>									

1 (M)
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05480

05480

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b exp. at home			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital				d. STREET ADDRESS 17701 Norwood Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Corinne		First Corinne Middle Last Butler		4. DATE OF DEATH April 7,		Day 19 Year 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1907	9. AGE (in years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Thomas				14. MOTHER'S MAIDEN NAME Alcinda Hill			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 		17. INFORMANT 		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis with 4201 DUE TO (b) myocardial Infarction; Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) Coronary Artery Heart Disease.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Belden R. Reap, M. D.		Address (Street, city, town, or county) Wharton, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/9/66		23c. NAME OF CEMETERY OR CREMATORY Sharp Street Cemetery		23d. LOCATION (City, town or county) (State) Sandy Spring, Md.	
24. FUNERAL DIRECTOR Robert L. Snowden		ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR APR 13 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05481

CERTIFICATE OF DEATH

05481

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN <u>2 mos. 3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>5 Hesketh St</u>	
3 NAME OF DECEASED (Type or print) <u>Lemuel</u> First Middle Last		4. DATE OF DEATH <u>April 17</u> 19 <u>66</u> Month Day Year	
5 SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/17/07</u> 58 yrs
10a. U.S. OCCUPATION (Give kind of work done during most of working life (even if retired). <u>Hardner - 1944-1950</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13 FATHER'S NAME <u>Harry L. Butler</u>		14 MOTHER'S MAIDEN NAME <u>Annice L. Dixon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17 INFORMANT <u>Sister Ruth Hall</u>		Address <u>3914 8th St. N.W. WASH. D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatitis Acute severe</u> <u>9327</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Thrombophlebitis & leg</u> DUE TO (c) <u>Amputation both feet gangrene post freezing</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>2 wks</u> <u>10 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-11</u> , 19 <u>66</u> , to <u>4-16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4-14</u> , 19 <u>66</u> , and that death occurred at <u>2:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Kent A Peterson</u> M.D.		22b. DATE SIGNED <u>4-17-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>KENT A PETERSON</u>		22d. ADDRESS <u>8218 Wisconsin Ave. Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4/21/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HARMONY MEMORIAL PARK</u>	23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON, D.C.</u>
24. FUNERAL DIRECTOR <u>SAM BUTLER INC. FUNERAL HOME, 3900 Ga. Ave., NW</u>		25a. REC'D BY REGISTRAR <u>APR 21 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05482

CERTIFICATE OF DEATH

05482

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN TB 12 days 2 1/2 hrs		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		d. STREET ADDRESS 5438 Broad Branch Rd NW e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Theodore Middle H. Last Calopedis		4. DATE OF DEATH Month April Day 21 Year 1966	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/13/11
9. AGE (In years, last birthday) 54 yrs.		10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF Employed		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME HARRY Calopedis		14. MOTHER'S MAIDEN NAME Sophia Fabake	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 1942-1948		16. SOCIAL SECURITY NO 182-22-9709	
17. INFORMANT Same as above		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, esophageal varices 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of liver DUE TO (c) years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from OCT 5, 1965 , to APRIL 21, 1966 , that (I) (we) last saw the deceased alive on 4/21 1966 , and that death occurred at 8:30 P.M. from causes and on the date stated above			
22a. SIGNATURE Dr. L. E. J. Donovan		22b. DATE SIGNED 4/22/66	
22c. PHYSICIAN'S NAME (Type) DR. L. E. J. DONOVAN		22d. ADDRESS FLYING WILSONS AVE BETHESDA MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/25/66	23c. NAME OF CEMETERY OR CREMATORY Mt. Rose Cemetery	23d. LOCATION (City or Town) (County) (State) York, Pennsylvania
24. FUNERAL DIRECTOR Jos. Gawler's Sons, Inc., Wash., D.C.		25a. REC'D BY REGISTRAR APR 26 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

CERTIFICATE OF DEATH

05483

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN IS <u>14 months</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>				d. STREET ADDRESS <u>5053 MASSACHUSETTS AVE. N.W.</u>			
3 NAME OF DECEASED (Type or print) <u>FRANK ROSA CARR</u>				4. DATE OF DEATH <u>APRIL 21 1966</u>			
5 SEX <u>F</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>MARCH 29, 1877</u>	
9 AGE (in years lost birthday) <u>89 yrs</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co., Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>William H. Oliver</u>			
14. MOTHER'S MAIDEN NAME <u>Beacham</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			
16 SOCIAL SECURITY NO. <u>-</u>				17. INFORMANT <u>John Carr</u> Address <u>5053 Mass Ave. N.W.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> 4 4 1 DUE TO (b) <u>Hypertensive heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Chronic heart failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u> <u>months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1940</u> , 19 <u>4-21-1966</u> to <u>4-21-1966</u> (1966) (1966) saw the deceased alive on <u>4-21-1966</u> , and that death occurred at <u>7:15 P.M.</u> from causes and on the date stated above							
22a. SIGNATURE <u>C.P. Ryland</u>				22b. DATE SIGNED <u>4-21-1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>C.P. RYLAND</u>				22d. ADDRESS <u>4400-49th St. Washington 16 DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>4/25/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	
23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>				23e. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>			
24. FUNERAL DIRECTOR <u>Jos. Gawler's Sons, Inc., Wash., D.C.</u>				25a. RECEIVED BY REGISTRAR <u>APR 26 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05484

05484

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) POTOMAC		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DEAD END OF TARA DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FREDERIC LEE CARTER		4. DATE OF DEATH APRIL 27 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/4/27
9. AGE (In years last birthday) 39 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHARMACIST	
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FREDERIC CARTER		14. MOTHER'S MAIDEN NAME THERESA MORGAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 123-16-3734	
17. INFORMANT URSULA CARTER WIFE (SAME)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u> 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>with semi-decapitation,</u> DUE TO (c) <u>apparently self-inflicted.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased shot self in head in local park & white.</u>	
20c. TIME OF INJURY 2:00 p.m. 4-27-1966	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) Potomac
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 4/27/1966	
ACTUAL SIGNATURE Belden R. Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-30-66	
23c. NAME OF CEMETERY OR CREMATORY ST. BERNARD CEM.		23d. LOCATION (City, town or county) (State) SARANAC LAKE, N.Y.	
24. FUNERAL DIRECTOR H. Don. DeVol		25a. REC'D BY REGISTRAR MAY 2 1966	
ADDRESS 2224 WIS. AVE.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



05485

CERTIFICATE OF DEATH

05485

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c LENGTH OF STAY IN 'b 15 - 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital		d. STREET ADDRESS 1401 Blair Mill Road	
3 NAME OF DECEASED (Type or print) First Middle Last MAX.. CHIDEL		4 DATE OF DEATH Month Day Year April 14 19 66	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1899
9 AGE (In years last birthday) yrs. 66		10. IF UNDER 1 YEAR Months Days 15 15	
10a. USUA. OCCUPATION (Give kind of work done during most of work life, even if retired) Self Employed		10b. KIND OF BUSINESS OR INDUSTRY Food	
11. BIRTHPLACE (County & State, or foreign country) Russia		12. CT. ZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Morris Chidel		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-48-2046	
17. INFORMANT Mrs. Selma Chidel		Address Same as 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Essential Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 18 days (c) 1 year			INTERVAL BETWEEN ONSET AND DEATH 18 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/4 , 19 66 , to 4/14 , 19 66 , that (I) (we) last saw the deceased alive on 4/14 , 19 66 , and that death occurred at 6:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Samuel Dessoff		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) SAMUEL DESSOFF		22d. ADDRESS 1382-18th N.W. WASH. D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 17, 1966	23c. NAME OF CEMETERY OR CREMATORY B'nai Israel Cemetery	23d. LOCATION (City or Town) (County) (State) Oxon Hill Md.
24. FUNERAL DIRECTOR Goldberg Funeral Home		25a. REC'D BY REGISTRAR APR 19 1966	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>7 yrs. 6 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u> d. STREET ADDRESS <u>4923 Brandywine St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Rebecca J. Charley</u>			4. DATE OF DEATH <u>April 11 1966</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH <u>11/4/1873</u>			9. AGE (in years last birthday) <u>92</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>German town, Md.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				
13. FATHER'S NAME <u>James E. Hoaman</u>					14. MOTHER'S MAIDEN NAME <u>Matilda Gloyd</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>Kensington Gardens Sanitarium Records</u>		17. INFORMANT <u>Kensington, Md.</u> Address <u>Interval between onset and death</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. cardiac failure -</u> DUE TO (b) <u>Arteriosclerotic heart disease -</u> DUE TO (c) <u>Smoked arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>50+ yrs -</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Smoked degenerative arteriosclerosis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>4-2</u> , 19 <u>66</u> , to <u>4-11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4-9</u> , 19 <u>66</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Alfred R. Henderson</u>					22b. DATE SIGNED <u>4-11-66</u>		22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. HENDERSON, M.D.</u>		
22d. ADDRESS <u>3201 WISCONSIN AVE WASHINGTON, D.C.</u>					23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/13/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>				
24. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u> ADDRESS <u>Washington, D. C.</u>					25a. REC'D BY REGISTRAR <u>APR 12 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05487

Items 2, 12 Film 6576 4/26/66 mh

05487

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BELLE VISTA</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Pr. Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> d. STREET ADDRESS <u>5TH UNIVERSITY BLVD. 1202 Kirklynn Ave</u> e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JANE ANN REID CHRISTIE</u> First Middle Last 4. DATE OF DEATH <u>APRIL 17 1966</u> Month Day Year		5. SEX <u>F.</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>JUNE 19-1871</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>GLASGOW SCOTLAND</u>		9. AGE (In years last birthday) <u>94</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>GLASGOW SCOTLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>Scotland</u>	
13. FATHER'S NAME <u>ALEXANDER J. CHRISTIE</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH M. ROSS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>1202 KIRKLYNN AVE. TAKOMA PK.</u>	
17. INFORMANT <u>MRS. WILSON CANTER</u>		Address <u>1202 KIRKLYNN AVE. TAKOMA PK.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Stomach</u> (c) <u>10 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 Mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>5 a.m. April 19 1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/8 1965</u> to <u>4/17 1966</u> that (I) (we) last saw the deceased alive on <u>4/17 1966</u> and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Harold Heiges</u>		22b. DATE SIGNED <u>4/17/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harold Heiges</u>		22d. ADDRESS <u>1835 Eye St NW</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APRIL 19-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>		23d. LOCATION (City, town or county) (State) <u>SILVER SPRING MONTG. MD.</u>	
24. FUNERAL DIRECTOR <u>Arthur Taltow</u>		25a. REC'D BY REGISTRAR <u>254 Carroll St</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		DATE <u>APR 20 1966</u>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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05488

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05488

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>One yr. 170</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>5940 R. 665 Rd., CHILLUM, MD.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Garden Sanitarium</u>				d. STREET ADDRESS <u>3000 McComas Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary</u>		First <u>A.</u> Middle <u>Citrano</u> Last		4. DATE OF DEATH <u>April 13-</u> 1966		Month Day Year	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 1-1894</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>ITALY</u>	
13. FATHER'S NAME <u>Ermano Tucci</u>				14. MOTHER'S MAIDEN NAME <u>CARMELLA De Ponziano</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>FRANK CITRANO 2nd ed above (HUSBAND)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio sclerosis cerebrale</u> <u>334X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>vascular disease</u> DUE TO (c) <u>gen. arterio sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>diabetes mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 8</u> , 19 <u>65</u> , to <u>4/13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/9</u> , 19 <u>66</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>4/13/66</u>		22c. PHYSICIAN'S NAME (Type) <u>16 F Kneuzburg</u>	
22d. ADDRESS <u>7A52 16th Ave NW Wash DC</u>				22e. REC'D BY REGISTRAR <u>APR 14 1966</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>ENTOMBMENT</u>		23b. DATE THEREOF <u>16 APRIL 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN MANSOLEUM</u>		23d. LOCATION (city, town or county) (State) <u>BLADENSBURG MD.</u>	
24. FUNERAL DIRECTOR <u>AL JALDI FUNERAL HOME</u>				25. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05489

CERTIFICATE OF DEATH

05489

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> D.O.A.				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>812 Grandin Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Rose Lee Chagett</u>				4. DATE OF DEATH <u>4-29</u> 19 <u>66</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/12/1911</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>12</u>		IF UNDER 24 HRS. Hours <u>12</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>supervisor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Sub. San. Com.</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph Lee Chagett</u>				14. MOTHER'S MAIDEN NAME <u>Grace Collins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-38-3101</u>		17. INFORMANT <u>Helen M. Chagett - 7 years</u> Address # <u>2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis</u> + 201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>oct</u> , 19 <u>66</u> to <u>29 April</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>28 April</u> , 19 <u>66</u> , and that death occurred at <u>12</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Wm. S. Murphy</u>				22b. DATE SIGNED <u>29 April 66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Wm. S. Murphy</u>				22d. ADDRESS <u>Rockville, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/2/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pk</u>				25a. REC'D BY REGISTRAR <u>May 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
Rockville, Maryland							



CERTIFICATE OF DEATH

05490

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 7 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 13325 NEW HAMPSHIRE AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last MARGUERITE VIRGINIA CLARK				4. DATE OF DEATH Month Day Year APRIL 19 1966			
5 SEX FEMALE		6 COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-28-98 8-25-98	
9 AGE (In years last birthday) 67		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DIOM. -- home		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
12 CITIZEN OF WHAT COUNTRY? USA				13 FATHER'S NAME FRANK TURNER			
14. MOTHER'S MAIDEN NAME ELIZA CLARK				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16 SOCIAL SECURITY NO. None				17 INFORMANT MEDICAL RECORDS Address OLNEY, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Myocardial Infarct DUE TO Arteriosclerosis of heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Diabetes Mellitus DUE TO Diabetes Mellitus (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1956 , 19, to 4/19 , 19 66 , that (I) (we) last saw the deceased alive on 4/18 , 19 66 , and that death occurred at 8:25 AM , from causes and on the date stated above.							
22a. SIGNATURE [Signature]				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/19/66	
22c. PHYSICIAN'S NAME (Type) CHARLES H. LIGON, M.D.				22d. ADDRESS MEDICAL CENTER, SANDY SPRING, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 22 April 1966		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or town) (County) (State) Prince George Co., Md.	
24. FUNERAL DIRECTOR Walter E. Humphrey, Jr.				25a. REC'D BY REGISTRAR APR 25 1966		25b. REGISTRAR'S SIGNATURE [Signature]	

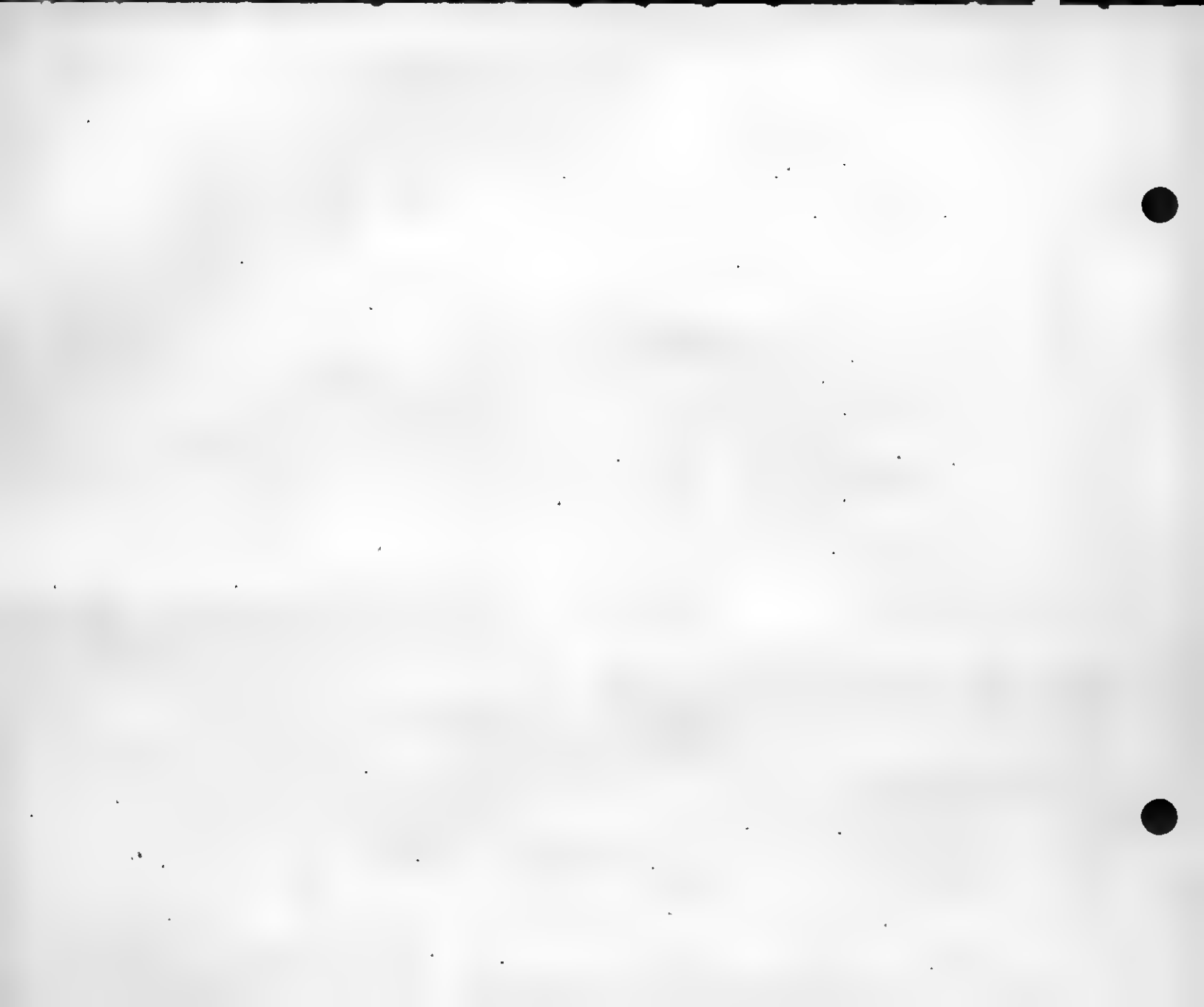
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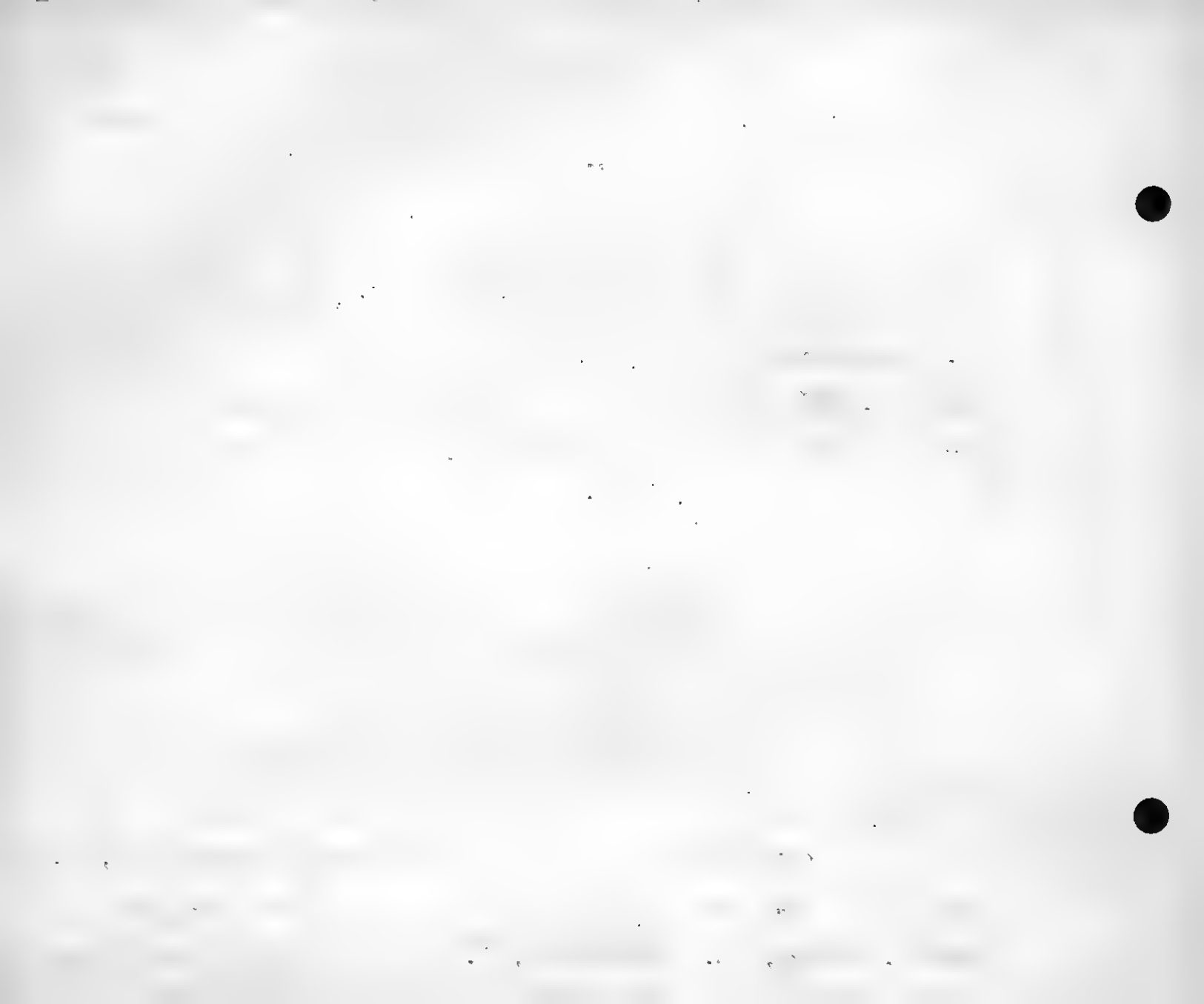
MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pt. Geo.</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakma Park</u>				c. LENGTH OF STAY IN 1b <u>3 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>						d. STREET ADDRESS <u>9215 Davidson Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>RICHARD</u> First <u>S.</u> Middle <u>CLARK</u> Last			4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1966</u>			5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 1, 1895</u>		9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - Railway Express</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railway Express</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York City</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edward Clark</u>						14. MOTHER'S MAIDEN NAME <u>Delia Burke</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>712 15 6823</u>		17. INFORMANT <u>Mrs. Katherine C. Davenport</u> Address <u>(same as #2)</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <u>GENERALIZED ADVANCED ARTERIOSCLEROSIS</u>										INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UREMIA</u>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>p.m.</u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>64</u> , to <u>APR 17</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>APR 17</u> , 19 <u>66</u> , and that death occurred at <u>7</u> PM, from the causes and on the date stated above.												
22a. SIGNATURE <u>Robert B. Irey</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>APR 18, 1966</u>				
22c. PHYSICIAN'S NAME (Type) <u>ROBERT B. IREY</u>						22d. ADDRESS <u>7105 Riggs Rd. Hyattsville, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>April 21, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Date of Heaven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>						
24. FUNERAL DIRECTOR <u>Sakma Funeral Home Inc.</u>		25a. RECD BY REGISTRAR <u>APR 20 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>05492</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>05492</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Sussex</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>1 week</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Branchville</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>						d. STREET ADDRESS <u>R.T.D. Culver Lake</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IRVING</u> Middle <u>Hill</u> Last <u>Coakley</u>			4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1966</u>			5. SEX <u>F.</u>			6. COLOR OR RACE <u>W.H.</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>12-30-1874</u>			9. AGE (In years last birthday) <u>91</u> yrs.			IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Private Secretary</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ELECTRICAL</u>				11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						13. FATHER'S NAME <u>George W. Coakley</u>					
14. MOTHER'S MAIDEN NAME <u>Isabella Hoe Godfrey</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>					
16. SOCIAL SECURITY NO. <u>147-36-8690</u>						17. INFORMANT <u>James E. Lamb</u> Address <u>2108 WAKEFIELD CT. ALEXANDRIA, VA.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 260X DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Diabetes</u> (c) <u>Diabetes</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? <u>NO</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4/21</u> , 19 <u>66</u> to <u>April 28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>April 28</u> , 19 <u>66</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>George Sharpe</u>						22b. DATE SIGNED <u>4-29-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>George Sharpe</u>						22d. ADDRESS <u>10511 Summit Avenue, Kensington, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2 May 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenfield Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Hempstead, New York</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>						25a. REC'D BY REGISTRAR <u>MAY 5 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05493											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>					
c. LENGTH OF STAY in b. <u>2 days</u>						15-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>						e. STREET ADDRESS <u>1611 E. Jefferson St</u>					
3. NAME OF DECEASED (Type or print) <u>Thomas Troy Coiner</u>						4. DATE OF DEATH <u>4-30-1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/2/09</u>		9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas A. Coiner</u>						14. MOTHER'S MAIDEN NAME <u>Bessie Troy</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <u>Yes</u>						16. SOCIAL SECURITY NO. <u>341-20-4267</u>		17. INFORMANT <u>Wife - Eva K - Same</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage, gastro-intestinal, massive</u> DUE TO (b) <u>Esophageal varices</u> DUE TO (c) <u>Portal cirrhosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>10</u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Years</u> <u>Year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4/28/66</u> , 19 <u>66</u> , to <u>4/30/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/30/66</u> , 19 <u>66</u> , and that death occurred at <u>2:55 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Frederick S Caldwell</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/30/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK S CALDWELL</u>						22d. ADDRESS <u>TERRY BLVD ROCKVILLE, MARYLAND</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>5-3-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>					
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. A ve, N.W. Wash. DC.</u>						25a. REC'D BY REGISTRAR <u>May 9 1966</u>					
						25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Items 18&21 Film G376 66666
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05494 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05491

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church d. STREET ADDRESS Patrick Henry Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth Pinnegar Connell		4. DATE OF DEATH Month April Day 4 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1907
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Franklin Pinnegar		14. MOTHER'S MAIDEN NAME Edith Irish	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Daughter & Medical Records Olney, Md.	
17. INFORMANT Daughter & Medical Records Olney, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction; Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) Multiple pulmonary emboli; DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		22. DATE SIGNED April 5, 1966	
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		Address (Street, city, town, or county) Wheaton	
23a. BURIAL, CREMATION, REMOVAL (Specify) Reburial		23b. DATE THEREOF 4/7/66	
23c. NAME OF CEMETERY OR CREMATORY Chastnut Grove Cemetery		23d. LOCATION (City, town or county) (State) Herndon, Va	
24. FUNERAL DIRECTOR Green Funeral Home - J. Blue - Herndon, Va.		25a. REC'D BY REGISTRAR APR 14 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

1
M
FOR STATE
HEALTH DEPT.

05495

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05495

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If city delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
c. LENGTH OF STAY IN 1b <u>2 yrs.</u>		d. STREET ADDRESS <u>3610 Lawrence Ave.</u>	
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3610 Lawrence Ave.</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>CECELIA E. CONRAD</u>		4 DATE OF DEATH <u>APRIL 19 1966</u>	
5 SEX <u>Fe</u>	6 CO. OR RACE <u>Cauc.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-17-1897</u> 68 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) <u>68</u> yrs
11 BIRTHPLACE (State or foreign country) <u>ennessee</u>		12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13 FATHER'S NAME <u>James Connolly</u>		14 MOTHER'S MARDEN NAME <u>Alice Miles</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT <u>Carl E. Conrad (Husband)</u>		Address <u>SAME</u>	
18 CAUSE OF DEATH (Enter only one cause per Part I. Death was caused by IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO <u>Cancer of Lung</u> (b) <u>163x</u> (c) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20a. TIME OF INJURY Month, Day Year <u>19</u>		20b. INJURY OCCURRED While at work <input type="checkbox"/> hot While at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>April 19, 1966</u>		Address (street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>4-21-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>mt Olivet cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Francis J. Collins</u> 3821-14th St NW, Wash, D.C.		25a. REC'D BY REGISTRAR <u>APR 20 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05496

CERTIFICATE OF DEATH

05496

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tarawa Terrace</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital Bethesda, Maryland</u>		d. STREET ADDRESS <u>3007 Saipan Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Debra Elaine Cook</u>		4. DATE OF DEATH <u>April 17 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 Feb 1966</u>
9. AGE (In years last birthday) <u>2</u> yrs.		10. IF UNDER 1 YEAR: Months <u>2</u> Days <u>6</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Jacksonville, Fla</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Larry L. Cook</u>		14. MOTHER'S MAIDEN NAME <u>Linda J. Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>Larry L. Cook</u>		18. ADDRESS <u>3007 Saipan Drive Tarawa Terrace, N. C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. <u>491X</u> IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 13</u> , 19 <u>66</u> , to <u>April 17</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>April 17</u> , 19 <u>66</u> , and that death occurred at <u>150</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>J. I. Lynch</u>		22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>18 April 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. I. Lynch</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-21-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>East End Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Cadiz, Kentucky</u>
24. FUNERAL DIRECTOR <u>W.W. Chambers Funeral Home</u>		25a. REC'D BY REGISTRAR <u>865</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>APR 19 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 201 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05497 CERTIFICATE OF DEATH 05497											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>19 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8319 Piney Branch Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Stanley</u> Middle <u>George</u> Last <u>Cook</u>						4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/7/91</u>		9. AGE (In years last birthday) <u>74</u> yrs. <u>75</u> yrs.		IF UNDER 1 YEAR: Months <u>1</u> Days <u>15</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Research Chemist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Navy Dept., U.S. Govt.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Cincinnati, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Cook</u>						14. MOTHER'S MAIDEN NAME <u>Alice McCaffrey</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-46-0380</u>		17. INFORMANT <u>Edna P. Cook</u>		Address <u>8319 Piney Branch Road Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Death myocardial infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> DUE TO (c) <u>None</u>										INTERVAL BETWEEN ONSET AND DEATH. <u>30 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary artery disease</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury) in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4/3/66</u> , 19 <u>66</u> , to <u>4/22</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/22</u> , 19 <u>66</u> , and that death occurred at <u>11:40 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Arthur J. Willets</u>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/23/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR J. WILETS</u>						22d. ADDRESS <u>1015 Spring St. Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>26 April, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>8474 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

05498

05498

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c LENGTH OF STAY IN It		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d STREET ADDRESS <u>710 Edgemore Lane</u> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Edmund B. Coolidge</u> First Middle Last		4 DATE OF DEATH <u>APRIL 19</u> Day Month Year 19 <u>66</u>	
5 SEX <u>Male</u>	6 COLOR OF RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/22/04</u>
9 AGE (In years, first birthday yrs) <u>61</u>		10 IF UNDER 1 YEAR Months Days Hours Min	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		12 KND OF BUSINESS OR INDUSTRY <u>Building</u>	
13 FATHER'S NAME <u>Edmund B. Coolidge</u>		14 MOTHER'S MAIDEN NAME <u>Margaret E. Bohrer</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO	
17 INFORMANT <u>Margaret E. Coolidge</u> Address <u>Item # 2</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia due to acute, severe, laryngeal</u> DUE TO (b) <u>edema, etiology unknown.</u> DUE TO (c) <u>lost</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Keap</u> EXAMINER'S NAME (Type) <u>BELDEN R. KEAP, M.D.</u>		22. DATE SIGNED <u>4/19/1966</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>4/22/66</u>	23c NAME OF CEMETERY OR CREMATORY <u>Rockville</u>	23d LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24 FUNERAL DIRECTOR <u>Tyson Wheeler</u> ADDRESS <u>1331 Rockville Pike Rockville, Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 22 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-21 Film G376 5/12/66 TM

05499

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15499

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brinklow, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		e. STREET ADDRESS 18700 New Hampshire Ave.	
3. NAME OF DECEASED (Type or print) Clarence Edward Cooper		4. DATE OF DEATH Month April Day 17 Year 1966	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/12/43
9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BU of Ed.		10b. KIND OF BUSINESS OR INDUSTRY Montg County	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Charles Henry Thomas		14. MOTHER'S MAIDEN NAME Adell Cooper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-9890	
17. INFORMANT Adell Thomas		Address Brinklow 18700 New Hampshire Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound, neck and chest, 981X DUE TO (b) with massive secondary hemorrhage DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased shot in reported altercation	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 2:15 p.m. 4/17 19 66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Silver Spring Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Bellden R. Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELODEN R. REAP M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED April 17, 1966		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/20/66	
23c. NAME OF CEMETERY OR CREMATORY Ash Memorial		23d. LOCATION (City, town or county) (State) Sanay Spring, Ma.	
24. FUNERAL DIRECTOR Robert L. Snowden		ADDRESS Rockville, Ma.	
25a. RECD BY REGISTRAR APR 22 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>19 days</u>		d. STREET ADDRESS <u>9310 Glenville Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bernard P</u> Middle <u>Cox</u> Last <u></u>		4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-17-10</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cable Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John F. Cox</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Milligen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Wife - Marie - Same</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 154X <u>BUN 207 Creatinine 7.3</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of Rectum</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>obesity - Bilateral pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u>1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-7</u> , 19 <u>66</u> to <u>4-21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/20</u> , 19 <u>66</u> , and that death occurred at <u>11:45</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>James H. Scully</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>James H. Scully</u>		22d. ADDRESS <u>1835 Eye St N.W. Wash D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/25/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Montgomery Co. Md.</u>	
24. FUNERAL DIRECTOR <u>W. H. Hunterman & Son Funeral Home</u>		25a. REC'D BY REGISTRAR <u>APR 25 1966</u>	
ADDRESS <u>5132 Ga Ave N</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 57 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 9002 Lindale Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Hilary Joan Crawhall		4. DATE OF DEATH Month Day Year April 9 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 June 1960
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY ---	9. AGE (In years last birthday) 5 yrs. IF UNDER 1 YEAR: Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? England	
13. FATHER'S NAME John C. Crawhall		14. MOTHER'S MAIDEN NAME Pamela Joyce Handoll	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Records, The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxic Hepatitis 2-4-3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Treatment for Acute Lymphocytic Leukemia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 month 18 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from 11 February, 1966 , to 9 April, 1966 , that he (we) last saw the deceased alive on 9 April 19 66 , and that death occurred at 7:55 M. from the causes and on the date stated above.			
22a. SIGNATURE Berton Zbar MD		22b. DATE SIGNED 9 April 1966	
22c. PHYSICIAN'S NAME (Type) Berton, Zbar, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 4-11-66	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City, town or county) (State) Suitland, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR APR 12 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 23b Film 3:76 5/5/66 mh

CERTIFICATE OF DEATH

05502

05502

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 164 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS 3 Bristol Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lenard Middle Baker Last CRESSWELL				4. DATE OF DEATH Month April Day 25 Year 1966			
5. SEX male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1901		9. AGE (In years last birthday) yrs 64	IF UNDER 1 YEAR Months 9 Days 7	IF UNDER 24 HRS Hours 7 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USMC		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) Lexington, Mississippi		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oliver May Cresswell				14. MOTHER'S MAIDEN NAME Ella Meek Baker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 6-18-44 to 6-30-56		16. SOCIAL SECURITY NO 425 78 0653		17. INFORMANT Annapolis, Md. Address Mrs. Emilia B. Cresswell, 3 Bristol Dr./			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacterial endocarditis associated with DUE TO bronchial pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) lost.						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe generalized arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from Nov. 22 , 19 66 , to April 25 , 19 66 , that he (we) last saw the deceased alive on April 25 , 19 66 , and that death occurred at 750A.M. from causes and on the date stated above.							
22a. SIGNATURE <i>S. J. Barcay</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED April 26, 1966	
22c. PHYSICIAN'S NAME (Type) S. J. Barcay, M. D.				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 28, 1966		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR R. A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Md.				25a. REC'D BY REGISTRAR DATE APR 28 1966		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and page 4 should be filed with the State Dept. of Health after death.

05503

CERTIFICATE OF DEATH

05503

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
c. LENGTH OF STAY IN 1b 3 wks		d. STREET ADDRESS 700 GUINCY ST. N.E.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNIVERSITY NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR JAMES - CROBY		4. DATE OF DEATH Month Day Year APRIL 9 1966	
5 SEX MALE	6 COLOR OR RACE CAUC	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-1893
9 AGE (in years last birthday) yrs 73		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Union Business Agent for		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) BOSTON- MASS		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME ARTHUR JAMES CROBY		14. MOTHER'S MAIDEN NAME MARY ROWAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 5 78-16-0904		16. SOCIAL SECURITY NO 5 78-16-0904	
17. INFORMANT Blanche A. Crobry,		Address Nile	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest 4201 DUE TO (b) CORONARY Occlusion Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (c) Arteriosclerosis - Generalized		INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebro Vascular Accident - 3 yrs ago.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from Feb - , 1966, to April 9, 1966 that (I) (we) last saw the deceased alive on Apr. 19, 1966 and that death occurred at 8 P.M. from causes and on the date stated above			
22a. SIGNATURE A. J. Vosger		22b. DATE SIGNED 4-9-66	
22c. PHYSICIAN'S NAME (Type) AZAD J. Vosger		22d. ADDRESS 10833 Stanmore Dr. Potomac	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 4/13/66	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Pt Geo Co Md.
24. FUNERAL DIRECTOR H. K. Huntemann		25a. REC'D BY REGISTRAR APR 12 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the funeral papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 12 hours after death.

VR AISME (5)
SM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05504

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05504

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN ID 20 minutes				d. STREET ADDRESS 5415 Connecticut Ave., N.W.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Laura Middle Elizabeth Last Cunningham		4. DATE OF DEATH Month April Day 20 Year 19 66			
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1891	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 2 Days 2	IF UNDER 24 HRS. Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dept. store buyer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lexington, Mass.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Dinan				14. MOTHER'S MAIDEN NAME Elizabeth Sheves			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Wash. D.C. Mr. John W. Cunningham, 5415 Conn. Ave., N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John G. Ball				22. DATE SIGNED 4/21/66			
EXAMINER'S NAME (Type) John G. Ball, M. D.				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 25/66		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Iysong's Funeral Home, 1300 N St. N.W. Washington				25a. REC'D BY REGISTRAR APR 25 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

D. C.



1
FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div> <div>05505</div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT</div> </div> </div> <div> <div> <div>05505</div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT</div> </div> </div> <div> <div> <div>05505</div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT</div> </div> </div> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>German town</u>				c. LENGTH OF STAY IN 1b <u>5 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>German town.</u>				d. STREET ADDRESS <u>Berryville Rd. Route #2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route #2 - Berryville Rd.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>William.</u> Middle <u>Vincent</u> Last <u>Dameron</u>			4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1966</u>			5. SEX <u>M.</u>			6. COLOR OR RACE <u>W.</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Feb 15, 1901</u>			9. AGE (In years last birthday) <u>65 yrs.</u>			IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret Representative</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Machinests Union</u>			11. BIRTHPLACE (State or foreign country) <u>West Moreland, Va.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Robert Edward</u>						14. MOTHER'S MAIDEN NAME <u>Jennie Allison</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>						16. SOCIAL SECURITY NO. <u>161-10-6053</u>			17. INFORMANT <u>Mrs. Monica Dameron</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage Intra Cerebral. Right Frontal.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Arterio Sclerosis - Severe -</u>						<u>years -</u>					
DUE TO (c) <u>Generalized Arterio Sclerosis -</u>						<u>years -</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.						22. DATE SIGNED <u>4/26/66</u>					
EXAMINER'S NAME (Type) <u>John G. Ball 7936 Old Geo Rd.</u>						Address (Street, city, town, or county) <u>Bethesda, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>27 April 1966</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>			23d. LOCATION (City, town or county) (State) <u>Prince George Co., Md.</u>		
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>						25a. REC'D BY REGISTRAR <u>APR 29 1966</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

pleased with Coroner for bill Simpson to sign

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05506									
CERTIFICATE OF DEATH									
07101									
1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		16-2
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital of Sil. Sp.</u>					d. STREET ADDRESS <u>620 Sheridan St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY Frances</u> Middle <u>xxx</u> Last <u>DAVIS</u>			4. DATE OF DEATH Month <u>4</u> Day <u>29</u> Year <u>1966</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 25, 1892</u>		9. AGE (in years last birthday) <u>74</u> yrs. <u>74</u> yrs. <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Robert Owillie Reichard</u>					14. MOTHER'S MAIDEN NAME <u>Mary Ellen Jones</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mary R. Simpson</u>		Address <u>Burke, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4201 DUE TO <u>Arteriosclerotic hypertensive heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Undet.</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Immed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 8, 1966</u> to present, 19 <u>66</u> , that (I) <u>two</u> last saw the deceased alive on <u>March 22-1966</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>William F. Simpson</u>				22b. DATE SIGNED <u>4/30/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>William F. Simpson</u>				22d. ADDRESS <u>6216 N. H. Ave NE - DC.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3 May 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince George, Co., Md.</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				24a. ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PNS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN ID <u>27 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>712 Easley Street</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>712 Easley Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY ELIZABETH DAYHOFF</u> First Middle Last		4. DATE OF DEATH <u>4-23</u> 1966 Month Day Year	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 8, 1913</u> 9. AGE (in years last birthday) <u>53</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN McCANN</u>		14. MOTHER'S MAIDEN NAME <u>Blanche Grove</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>578-28-4408</u>	
17. INFORMANT <u>Lillian M. Easton (Daughter)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial failure associated</u> DUE TO (b) <u>with aspiration of gastric contents.</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased vomited and aspirated gastric content.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>6:00</u> <u>AM</u> <u>4/23</u> 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Silver Spring</u> (County) <u>Montg</u> (State) <u>Md.</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Belden R. Reap M.D.</u> NAME (Type) <u>BELDEN R. REAP M.D.</u>		22. DATE SIGNED <u>4/23/1966</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>27 April 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown, Md.</u>	
24. FUNERAL DIRECTOR <u>John S. Thomas</u> ADDRESS <u>8434 Georgia Avenue</u> <u>Warner E. Humphrey, Inc. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 27 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT.

05508

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05507

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>5 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hosp.</u>		e. STREET ADDRESS <u>7611 Georgia Ave.</u>	
3 NAME OF DECEASED (Type or print) First <u>MELVERTA</u> Middle <u>DIFFENBAUGH</u> Last <u>DIFFENBAUGH</u>		4 DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-20-99</u> 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical</u>		11 BIRTHPLACE (State or foreign country) <u>PENNA.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>GOV'T.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Frank Nesiterode</u>		14 MOTHER'S MAIDEN NAME <u>Mella C'Hara</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>- - -</u>	
17. INFORMANT <u>HOSP. RECORDS</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive exsanguination due to ruptured</u> <u>4621</u> DUE TO (b) <u>esophageal varices.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street office bldg. etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>4-5-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or town) (County) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REG. STRA <u>APR 7 1966</u>	
ADDRESS <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

- Cleared to Dr. Deep (ventilator) / J. K. Keadal

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
05509		05508							
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			c. LENGTH OF STAY IN 1b <u>13 1/2 hr</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>					d. STREET ADDRESS <u>4406 AMBLER DRIVE</u>				
3. NAME OF DECEASED (Type or print) First <u>FRANCES</u> Middle <u>-</u> Last <u>DONOHUE</u>					4. DATE OF DEATH Month <u>APRIL</u> Day <u>3</u> Year <u>1966</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>WH</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/16/26</u>		9. AGE (in years last birthday) <u>40</u> yrs. IF FUNER 1 YEAR <u>1</u> Months <u>17</u> Days <u>17</u> Hours <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WASH. DC.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lawrence B. Morris</u>					14. MOTHER'S MAIDEN NAME <u>Helen Gleason</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT J.E. Donohoe 3404 Nimitz Rd., Kensington				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC FAILURE</u> <u>2810</u> DUE TO <u>CIRRHOSIS OF LIVER</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2810</u> DUE TO <u>CIRRHOSIS OF LIVER</u> (c) <u>CIRRHOSIS OF THE LIVER SEVERE</u>								INTERVAL BETWEEN ONSET AND DEATH <u>28</u> MONTHS <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CIRRHOSIS OF THE LIVER SEVERE</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>April 2, 1966</u> to <u>April 3, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 3, 1966</u> , and that death occurred at <u>9:14</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Abraham W. Danish</u>					22b. DATE SIGNED <u>4-4-66</u>				
22c. PHYSICIAN'S NAME (Type) <u>ABRAHAM W. DANISH</u>					22d. ADDRESS <u>1106 SPRING ST SE. MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>3/6/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>		
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey F.H.</u>					ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Classified to Mr. J. Ball (medical examiner) J. W. Hall

BP

UNITED STATES DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05510

05509

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN b 3 Hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Martinsvury c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Martinsvury d. STREET ADDRESS Whites Ferry Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edna Middle Mae Last Dorsey		4. DATE OF DEATH Month April Day 15 Year 1966	
5. SEX F		6. COLOR OR RACE N	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-3-08	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Fairfax		14. MOTHER'S MAIDEN NAME Sarah C. Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure DUE TO (c) Arteriosclerotic cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mitral stenosis INTERVAL BETWEEN ONSET AND DEATH acute			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/15 , 19 66 , to 4/15 , 19 66 , that (I) (we) last saw the deceased alive on 4/15 , 19 66 , and that death occurred at 10 PM , from the causes and on the date stated above.			
22a. SIGNATURE Richard H. Pollen		22b. DATE SIGNED 4/16/66	
22c. PHYSICIAN'S NAME (Type) RICHARD H. POLLEN		22d. ADDRESS 10511 SUMMIT AVE, KENSINGTON, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-20-66	
23c. NAME OF CEMETERY OR CREMATORY Warren Church,		23d. LOCATION (City, town or county) (State) Martinsburg, Mo.	
24. FUNERAL DIRECTOR Robert L. Swarden		ADDRESS Rockville, Md.	
25a. REC'D BY REGISTRAR APR 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8308 Flower Ave</u>						d. STREET ADDRESS <u>8308 Flower Avenue</u>						
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ZITA</u> Last <u>DORSEY</u>						4. DATE OF DEATH Month <u>4</u> Day <u>24</u> Year <u>1966</u>						
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/16/95</u>		9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk- Fidelity Investment Co.</u>						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Washington, D. C</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George E. Weide</u>						14. MOTHER'S MAIDEN NAME <u>Wilhemina Huneke</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>						16. SOCIAL SECURITY NO. <u>5-1-18-7-31-1919</u>		17. INFORMANT <u>Mrs. Elsie Weide-5409 Center St.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u>Chester Chase Md.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>Belden R. Reap</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <u>4/24/66</u>				
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Charles Judge</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>4/26/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>				
24. FUNERAL DIRECTOR <u>The S. H. Hines Company</u>				ADDRESS <u>-2901 14th St</u>		25a. REC'D BY REGISTRAR <u>APR 26 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				
Washington, D. C.												

1911

1912

1913

1914

24 hours after death. Page 4 retained by the hospital or attending physician. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in by the funeral director. After this certificate has been signed by the attending physician and completely in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ROCKVILLE MD		c. LENGTH OF STAY IN lb 4 YEARS		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 404 NINA PLACE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 404 NINA PLACE		4. DATE OF DEATH APRIL 15 1966		5. SEX MALE	
3. NAME OF DECEASED (Type or print) RAYMOND JOHN DOYLE, SR.		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 15, 1900		9. AGE (In years last birthday) 66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ADMINISTRATIVE - VA		10b. KIND OF BUSINESS OR INDUSTRY VETERANS ADM.		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, DC		12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME THOMAS M DOYLE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WORLD WAR I		16. SOCIAL SECURITY NO. 578-54-8774		17. INFORMANT MRS. JOSEPHINE DOYLE		Address 404 NINA PLACE		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1532 DUE TO CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. GENERALIZED CARCINOMATOSIS DUE TO CARCINOMA DESCENDING COLON	
19. INTERVAL BETWEEN ONSET AND DEATH IMMED		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE WITH OLD MYOCARDIAL INFARCTION		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		22. DATE SIGNED 15 APRIL 1966		23. TIME OF INJURY Hour a.m. p.m. 19	
24. TIME OF INJURY Month, Day, Year 19		25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 19		26. (City or town) 19		27. (County) 19		28. (State) 19	
29. I certify that (I) (this hospital) attended the deceased from FEBRUARY 1965 to APRIL 15, 1966 that (I) (we) last saw the deceased alive on 13 APRIL 1966 and that death occurred at 935 PM from the causes and on the date stated above		30. SIGNATURE FREDERICK S CALDWELL		31. ATTENDING PHYS. <input checked="" type="checkbox"/>		32. MED. DIRECTOR <input type="checkbox"/>		33. STAFF PHYS. <input type="checkbox"/>	
34. NAME OF PHYSICIAN'S NAME (Type) FREDERICK S CALDWELL		35. ADDRESS TEMPLE BLVD ROCKVILLE, MARYLAND		36. DATE 15 APRIL 1966		37. SIGNATURE Charles Judge		38. REC'D BY REGISTRAR APR 20 1966	
39. BURIAL, CREMATION, REMOVAL (Specify) Burial		40. DATE THEREOF 4-19-1966		41. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.		42. LOCATION (City, town or county) Arlington, Va.		43. (State) 19	
44. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons, Inc.		45. ADDRESS 5130 Wisc. Ave. N.W. Wash. DC.		46. REC'D BY REGISTRAR APR 20 1966		47. REGISTRAR'S SIGNATURE Charles Judge		48. DATE APR 20 1966	



05513

CERTIFICATE OF DEATH

05512

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN lb <u>33 hrs.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d STREET ADDRESS <u>7000 CYNTHIA LANE</u>	
3 NAME OF DECEASED (Type or print) <u>JOHANNA B DROSTE</u>		4 DATE OF DEATH Month <u>APRIL</u> Day <u>23</u> Year <u>1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/1/82</u>
9 AGE (n years last birthday) <u>83</u>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <u>Germany</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Herman BRUEGGEMANN</u>		14 MOTHER'S MAIDEN NAME <u>Ottillie IHNE</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO.	
17 INFORMANT <u>Mrs. Hermina Hyatt</u>		Address <u>Granddaughter / Same as above</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>21 April, 1966</u> , to <u>23 April, 1966</u> , that (I) (we) last saw the deceased alive on <u>23 April 1966</u> , and that death occurred at <u>1253</u> M, from causes and on the date stated above			
22a SIGNATURE <u>JERE J. DAUM</u> M.D.		22b. DATE SIGNED <u>23 April</u>	
22c PHYSICIAN'S NAME (Type) <u>JERE J. DAUM</u>		22d ADDRESS <u>4977 Battery Lane Bethesda</u>	
23a BURIAL CREMATION REMOVAL (Specify)	23b DATE THEREOF <u>4/25/1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d LOCATION (City or Town) (County) (State) <u>Switzland Prince George's Md</u>
24 FUNERAL DIRECTOR <u>Matheny 135-11th St. S.E. D.C.</u>		25a REC'D BY REGISTRAR DATE <u>APR 25 1966</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
20 M 1/66

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p> </div> <div> <p>05514</p> <p>05513</p> </div> </div>									
<p>1. PLACE OF DEATH</p> <p>a. COUNTY Montgomery MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase</p> <p>c. LENGTH OF STAY IN 1b</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4412 Cumberland Street</p>					<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE Maryland b. COUNTY Montgomery</p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase</p> <p>d. STREET ADDRESS 4412 Cumberland Street</p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>				
<p>3. NAME OF DECEASED (Type or print)</p> <p>First ARMAND Middle Budington Last DuBOIS</p>					<p>4. DATE OF DEATH</p> <p>Month April Day 19 Year 19 66</p>				
<p>5. SEX Male</p>		<p>6. COLOR OR RACE White</p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH Oct. 17, 1908</p>		<p>9. AGE (in years last birthday) 57 yrs.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney</p>				<p>10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't</p>		<p>11. BIRTHPLACE (State or foreign country) New York</p>		<p>12. CITIZEN OF WHAT COUNTRY? U. S.</p>	
<p>13. FATHER'S NAME Chester DuBois</p>					<p>14. MOTHER'S MAIDEN NAME Hilda Budington</p>				
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)</p>					<p>16. SOCIAL SECURITY NO. 216-44-4145</p>		<p>17. INFORMANT Wife Address Same as Item 2. Alexandria P. DuBois</p>		
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning</p> <p>7731</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>DUE TO (b)</p> <p>DUE TO (c)</p>									<p>INTERVAL BETWEEN ONSET OF DEATH 72 Hr.</p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)</p>									
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.</p>					<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Sat in his car in a closed garage and ran motor.</p>				
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. 10 4/19 1966</p>			<p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) house-garage</p>		<p>20f. (City or town) Chevy Chase Mont. Md. (County) (State)</p>		
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input checked="" type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p>									
<p>ACTUAL SIGNATURE John G. Ball</p>					<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>				
<p>EXAMINER'S NAME (Type) JOHN G. BALL</p>					<p>M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p> <p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4/20/66</p> <p>Address (Street, city, town, or county) Bethesda, Md.</p>				
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation</p>			<p>23b. DATE THEREOF 4-20-66</p>		<p>23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory</p>		<p>23d. LOCATION (City, town or county) (State) Suitland, Maryland</p>		
<p>24. FUNERAL DIRECTOR ROBERT A. PUMPHREY</p>					<p>ADDRESS Bethesda, Maryland</p>		<p>25a. REC'D BY REGISTRAR APR 21 1966</p>		<p>25b. REGISTRAR'S SIGNATURE f Charles Judge</p>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be prepared within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Declared by Dr. Robert F. Kreuzburg

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05515									
05514									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN ID <u>1 1/2 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			d. STREET ADDRESS <u>11704 College View Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital of S.S.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>William CARROLL Dyer</u>		4. DATE OF DEATH <u>4/27/66</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>5/24/23</u>		9. AGE (In years last birthday) <u>42</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vice Pres/Director</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mem Associate</u>		11. BIRTHPLACE (County & State, or foreign country) <u>California</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>HARRILL STRAS DYER</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE HARRIETT RECTOR</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W.H. 560-20-1693</u>	
17. INFORMANT <u>Cherilyn Dyer</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <u>March 26, 1966</u> to <u>April 27, 1966</u> , that (1) (we) last saw the deceased alive on <u>April 27, 1966</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>4/27/66</u>		22c. PHYSICIAN'S NAME (Type) <u>R.F. Kreuzburg</u>		22d. ADDRESS <u>7852 16th St NW Wash DC</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/2/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L</u>		23d. LOCATION (City, town or county) (State) <u>ARLINGTON VIRGINIA</u>		24. FUNERAL DIRECTOR <u>W.W. CHAMBERS INC - SILVER SPRING, MD</u>	
25a. REC'D BY REGISTRAR <u>MAY 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

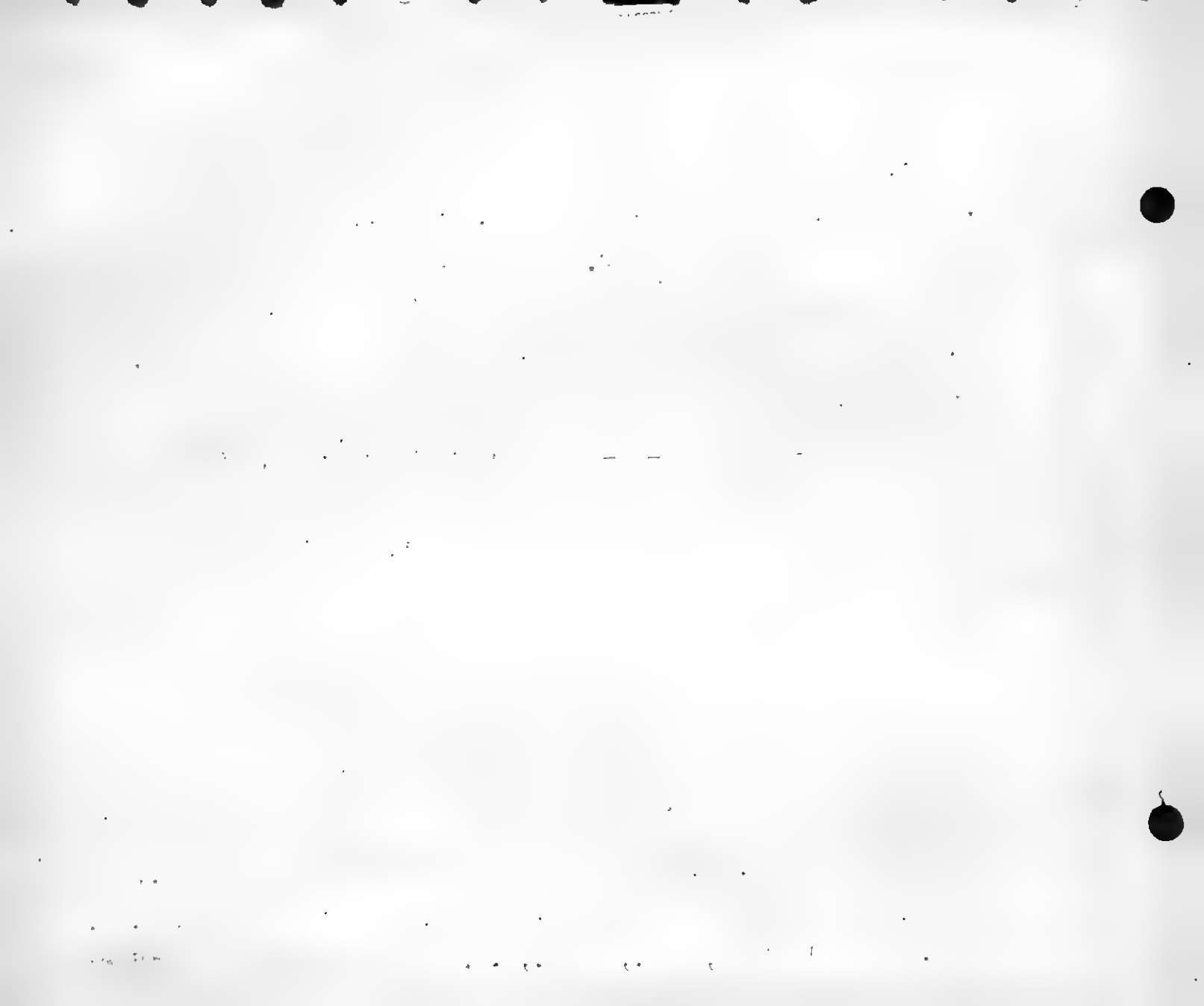
VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 9005 Mohawk Lane	
3. NAME OF DECEASED (Type or print) First PAUL Middle K. Eadeh Last EADAH		4. DATE OF DEATH Month April Day 21 Year 1966	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/28/82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Importer		10b. KIND OF BUSINESS OR INDUSTRY Import-Export	
11. BIRTHPLACE (County & State, or foreign country) Jordan		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Khallel Eadeh		14. MOTHER'S MAIDEN NAME Katherin Totah	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 225-42-0758	
17. INFORMANT Jessie Eliot Eadeh, Wife		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis Generalized (c) years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1969 to date , 19 66 , that (I) (we) last saw the deceased alive on 4/20 19 66 , and that death occurred at 3:30 PM, from the causes and on the date stated above.			
22a. SIGNATURE John G. Ball		22b. DATE SIGNED 4/21/66	
22c. PHYSICIAN'S NAME (Type) John G. Ball		22d. ADDRESS 7936 Old Georgetown Rd., Bethesda Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/25/66	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR Jos. Gawler's Sons, Inc., Wash., D.C.		25a. REC'D BY REGISTRAR APR 26 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

05517

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05516

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4307 Lynbrook Dr.</u>		e. STREET ADDRESS <u>4307 Lynbrook Dr.</u>	
3 NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Harvey</u> Last <u>Edmonston</u>		4 DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1966</u>	
5 SEX <u>M.</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/6/1908</u>
9 AGE (In years last birthday) <u>58</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Deputy Chief</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Federal Parks</u>	
11 BIRTHPLACE (State or foreign country) <u>Washington-D.C.</u>		12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13 FATHER'S NAME <u>David B. Edmonston</u>		14 MOTHER'S MAIDEN NAME <u>Bessie Coker</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>578-56-5002</u>	
17 INFORMANT <u>Wife: Helen Dyre Edmonston</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhagic Pancreatitis Acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Gastritis</u> (c) <u>Sudden</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4/11/66</u>	
		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b DATE THEREOF <u>4/12/66</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>		23d LOCATION (City or town) (County) (State) <u>Washington, D.C.</u>	
24 FUNERAL DIRECTOR <u>L. Wm. Lee FUNERAL HOME</u>		25a REC'D BY REGISTRAR <u>APR 18 1966</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

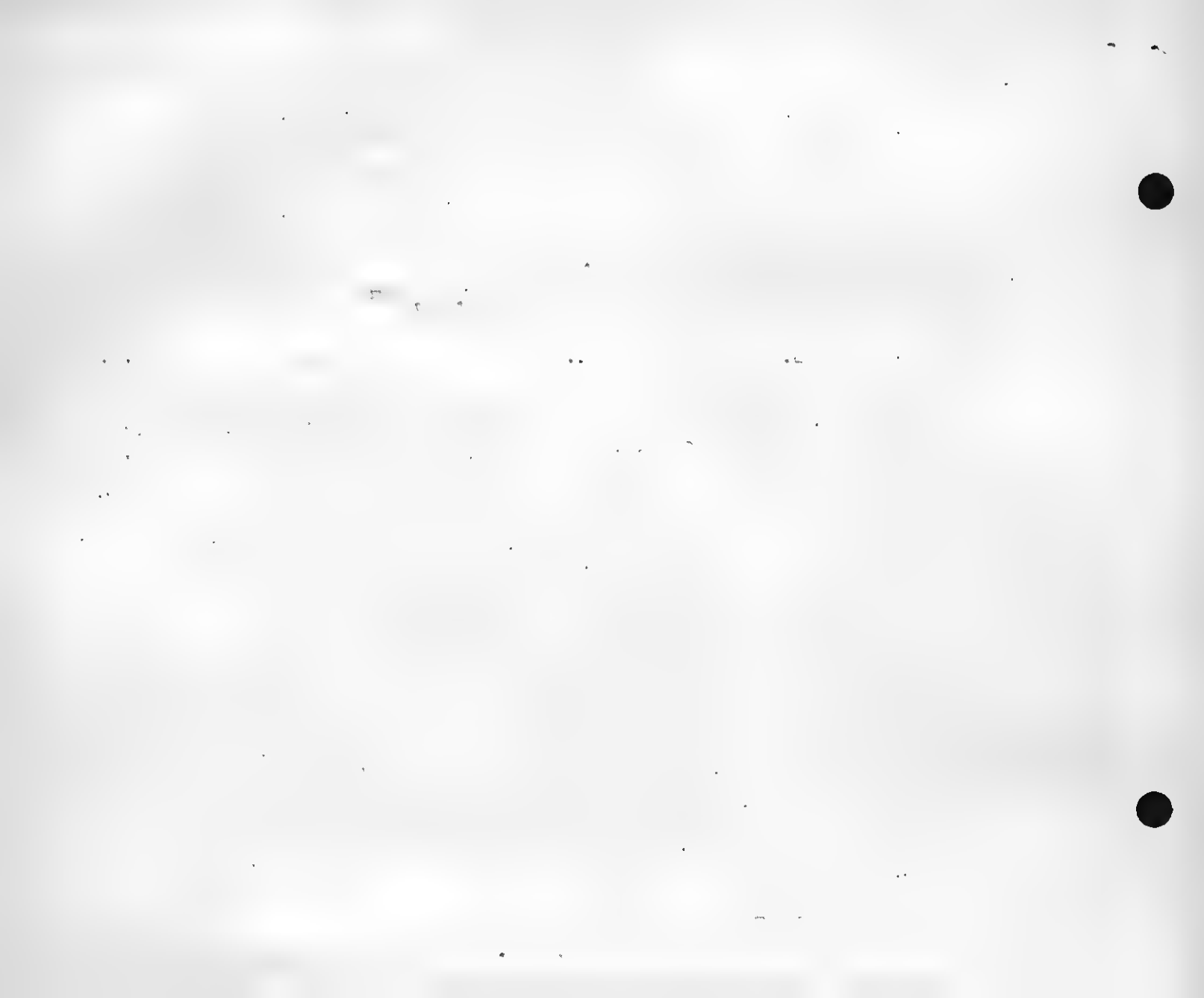
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
05518
05517
Cleared to Medical Examiner

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery County				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington D.C.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital				d. STREET ADDRESS 7001 3rd St. N.W. Wash. D.C.			
3. NAME OF DECEASED (Type or print) First Charles Middle S. Last Elder				4. DATE OF DEATH Month 4 Day 20 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 15, 1877	
9. AGE (In years last birthday) 88 yrs.		10. MONTHS 6		11. DAYS 5		12. HOURS Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President of Co.				10b. KIND OF BUSINESS OR INDUSTRY Tool Manfu.			
11. BIRTHPLACE (County & State, or foreign country) Hamilton, Ontario, Can.				12. CITIZEN OF WHAT COUNTRY? U.S. (nat.)			
13. FATHER'S NAME Alexander Elder				14. MOTHER'S MAIDEN NAME Margaret Edwards			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 077-09-1654			
17. INFORMANT (Daughter) Lucile Bryan				17. ADDRESS 5115 Bradley Blvd Chevy Chase, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST H.F.B.A. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS & DUE TO (c) (PNEUMONIA) EMPHYSEMA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MILD Diabetes mellitus						INTERVAL BETWEEN ONSET AND DEATH MINS. YEARS YEARS	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from APRIL 18, 1966, to APRIL 20, 1966, that (I) (we) last saw the deceased alive on APRIL 19, 1966, and that death occurred at 8:00 a.m. from the causes and on the date stated above.							
22a. SIGNATURE Harold W. Draper				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED APRIL 20, 1966	
22c. PHYSICIAN'S NAME (Type) HAROLD W. DRAPER, M.D.				22d. ADDRESS 911 SILVER SPRING AVE SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-25-66		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY Bethesda, Md.				25a. REC'D BY REGISTRAR APR 25 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Noted with Medical Examiner

M 05518

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05518

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY in b <u>D.O.A.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. + Hosp</u>				e. STREET ADDRESS <u>6209 41st Place</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM E. ENGLE</u>				4. DATE OF DEATH Month Day Year <u>Apr. 23 1966</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-15-01</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>engineering firm</u>			
13. FATHER'S NAME <u>John E. Engle</u>				14. MOTHER'S MAIDEN NAME <u>Wilhelmina ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>214-09-5915</u>		17. INFORMANT <u>Emily N. Engle</u> Address <u>same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery Disease</u> DUE TO (c) <u>Coronary insufficiency</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous Coronary Thrombosis 1952 - 60</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>1955</u> , 19 <u>66</u> to <u>4-23</u> , 19 <u>66</u> , that (I) <u>last</u> saw the deceased alive on <u>4-15</u> , 19 <u>66</u> , and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>R.D. Bauer M.D.</u>				22b. DATE SIGNED <u>4-23-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>R.D. Bauer M.D.</u>				22d. ADDRESS <u>2513 Buckhage Rd - Bethesda Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 24, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT. Lincoln</u>		23d. LOCATION (City, town or county) (State) <u>Colmar Manor Md</u>	
24. FUNERAL DIRECTOR <u>F. Lassko Son. Hyattsville Md</u>				25a. REC'D BY REGISTRAR <u>APR 27 1966</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

1 (M)
FOR STATE
HEALTH DEPT.

05520

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05519

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>POA.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Westchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York</u> d. STREET ADDRESS <u>300 Fort Washington St</u>	
3. NAME OF DECEASED (Type or print) First <u>Maria</u> Last <u>Ramirez Fajardo</u>		4. DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr.</u>
9. AGE (In years last birthday) <u>74</u>		10. FUNDING YEAR Months <u>1</u> Days <u>1</u> Hours <u>19</u> Min <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Cuba</u>		12. CITIZEN OF WHAT COUNTRY? <u>Cuba</u>	
13. FATHER'S NAME <u>Nieve Ramos</u>		14. MOTHER'S MAIDEN NAME <u>Luiz Romeo</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Alberto Fajardo</u>		Address <u>104 Quebec St</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary Artery Heart Disease</u> (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County)	
20g. (State)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Read M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. READ M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>April 2, 1966</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u>Wheaton Md</u>		23. LOCATION (City or town) (County) (State)	
23a. BURIAL CREMATION, REMOVAL OR OTHER <u>Burial</u>		23b. DATE THEREOF <u>April 6, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace</u>		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR <u>Funeral H. 7400 S. Ave. W.</u>		25a. REC'D BY REGISTRAR <u>APR 5 1966</u>	
Address <u>Wash DC</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05521

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05521

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
c. LENGTH OF STAY IN 1b 5 1/2 hours		d. STREET ADDRESS 8505 SPRINGVALE TERR	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOLY CROSS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ERNEST W. FARLEY		4. DATE OF DEATH Month Day Year 4 9 1966	
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-16-83
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PHARMACIST		10b. KIND OF BUSINESS OR INDUSTRY Drugs	
11. BIRTHPLACE (County & State, or foreign country) Richmond, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Farley		14. MOTHER'S MAIDEN NAME Rosa Morrisette	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 577-030171	
17. INFORMANT DAUGHTER RUTH LINTHICUM		Address 12113 VILLAGE SQUARE ROCKVILLE, MD 20850	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (a) Diabetes Mellitus (b) Pulmonary embolism (c) Renal (sub 120)			INTERVAL BETWEEN ONSET AND DEATH 9 hours 72 hours
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 1965 , to April 9, 1966 , that (I) (we) last saw the deceased alive on April 9, 1966 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Gene U. Cohen, M.D.			22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) GENE U. COHEN, M.D.		22d. ADDRESS 1106 SPRING ST SILVER SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/11/1966	23c. NAME OF CEMETERY OR CREMATORY Mary Cemetery	23d. LOCATION (City, town or county) (State) Richmond, Virginia
24. FUNERAL DIRECTOR Ernest E. Purphrey, Inc.		25a. REC'D BY REGISTRAR APR 13 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05522

Item 1d Film 436 2/2/66

05521

1. PLACE OF DEATH
a. COJNTY

Montg

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Gaithersburg

c. LENGTH OF STAY IN

7yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

521 S. Frederick Ave.

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Katherine

Elizabeth

Fauver

4. DATE OF DEATH

Month

Day

Year

Apr

20th 1966

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

Feb 14th 1907, 59 yrs.

9. AGE (in years last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House Wife

10b. KIND OF BUSINESS OR INDUSTRY

III

11. BIRTHPLACE (County & State, or foreign country)

Penn,

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

John Henderson

14. MOTHER'S MAIDEN NAME

Mary Hartley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Charles E. Fauver. As No 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Cerebral Vascular Thrombosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Cerebral Arteriosclerosis

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Arteriosclerotic Heart Disease with congestive heart failure, Diabetes Mellitus.

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m.
p.m.

Month, Day, Year

19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Oct. 4, 1963, to 4/20, 1966, that (I) (we) last saw the deceased alive on March 31, 1966, and that death occurred at .. M, from the causes and on the date stated above.

22a. SIGNATURE

Robert C. Macon

M.D.

ATTENDING PHYS ☒

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

Robert C. Macon, M.D.

22d. ADDRESS

809 Viers Mill Rd. Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

4-22-66

23c. NAME OF CEMETERY OR CREMATORY

Neelsville

23d. LOCATION (City, town or county)

Germantown, Rural, Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Charles E. Fauver, Gaithersburg, Md.

25a. REC'D BY REGISTRAR

APR 22 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05523

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05522

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c LENGTH OF STAY IN 1b <u>Bethesda</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				e STREET ADDRESS <u>6029 Grosvenor Lane</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Park Finlayson</u>				4 DATE OF DEATH Month Day Year <u>4 21 1966</u>			
5 SEX <u>Fe</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/1-96</u>	9 AGE (n years last birthday) <u>70</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUA. OCC. PAT. ON (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Georgia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK PARK</u>				14. MOTHER'S MAIDEN NAME <u>Emma Bridges</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-44-9302</u>		17 INFORMANT Address <u>Florence Alden Finlayson Same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary Thrombosis Acute</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Advanced Coronary Arterio Sclerosis</u> years (c) <u>Generalized Arterio Sclerosis -</u> years						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.				22. DATE SIGNED <u>4/22/66</u>			
EXAMINER'S NAME (Type) <u>John G. Ball</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4/25/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges County Md.</u>	
24. FUNERAL DIRECTOR <u>The S.H. Hines Company</u> Address <u>2901 Washington, N.W.</u>				25a. REC'D BY REGISTRAR <u>APR 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>2 mo. 2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. Hosp.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>12127 Dahlwood Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Verbin</u> Middle <u>Forest</u> Last <u>FORE</u>			4. DATE OF DEATH Month <u>4</u> Day <u>2</u> Year <u>1966</u>			5. SEX <u>M</u>			6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Heavy Equip. operator</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>			11. BIRTHPLACE (County & State, or foreign country) <u>ALABAMA</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Calvin Fore</u>						14. MOTHER'S MAIDEN NAME <u>ADA BRASLEY</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>			16. SOCIAL SECURITY NO. <u>W.W. H 421-16-2855</u>			17. INFORMANT <u>Hosp. Records</u>			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM</u> <u>1962</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ADENOCARCINOMA WITH GENERALIZED METASTASIS - MENTH</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>RECENT</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>30 Jan, 1966</u> to <u>2 April, 1966</u> , that (I) (we) last saw the deceased alive on <u>1 April 1966</u> , and that death occurred at <u>7:15 M.</u> from the causes and on the date stated above.												
22a. SIGNATURE <u>Boris Rabkin</u>						22b. DATE SIGNED <u>2 April 1966</u>			22c. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>			
22d. ADDRESS <u>1019 Univ Blvd, Ex Silver Spring, Md</u>						22e. M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>4/4/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MILBORNE CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>STEEL, ALABAMA</u>				
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS, INC SILVER SPRING, MD</u>						25a. REC'D BY REGISTRAR <u>APR 7 1966</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE South Dakota b. COUNTY Union				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN b 448 Days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Maryland					d. STREET ADDRESS (No street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Richard James Frieberg			4. DATE OF DEATH Month April Day 17 Year 1966						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 February 1937		9. AGE (In years last birthday) 29 yrs. IF UNDER 1 YEAR Months 29 Days 29 Hours 29 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer				10b. KIND OF BUSINESS OR INDUSTRY Law		11. BIRTHPLACE (County & State, or foreign country) South Dakota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roscoe Frieberg					14. MOTHER'S MAIDEN NAME Bessie Bacon				
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1960 - 1961		17. INFORMANT The Medical Record, Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Gram-Negative Septicemia 2043 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) Acute Myelogenous Leukemia OUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 12 Hours 16 Months									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from 24 January, 1965 , to 17 April, 1966 , that (we) last saw the deceased alive on 17 April 1966 , and that death occurred at 4:45M , from the causes and on the date stated above.									
22a. SIGNATURE Herman A. Godwin, Jr. (M.D.)					22b. DATE SIGNED 17 April 1966				
22c. PHYSICIAN'S NAME (Type) Herman A. Godwin, MD					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-20-66		23c. NAME OF CEMETERY OR CREMATORY Beresford		23d. LOCATION (City, town or county) (State) Beresford SD			
24. FUNERAL DIRECTOR Robert E. Wilhelm					25a. REC'D BY REGISTRAR APR 20 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

FOR STATE HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05525

05526

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>160 Talbot St</u>		d. STREET ADDRESS <u>160 Talbot St. Off E 2</u>	
3 NAME OF DECEASED (Type or print) <u>Ruth Annamoy Fries</u>		4. DATE OF DEATH <u>April 26 19 66</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7/26/22</u>
9 AGE (In years last birthday) <u>43</u> yrs		IF UNDER 1 YEAR: Months <u>9</u> Days <u>0</u> F UNDER 24 HRS: Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	
11 BIRTHPLACE (State or foreign country) <u>Chicago, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Andrew. c. Fries.</u>		14. MOTHER'S MAIDEN NAME <u>Annamoy - Frey.</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of serv ce) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>321-28-9581</u>	
17. INFORMANT <u>Brother</u> Address <u>1005 Chillum Rd. W. Hyattsville, Md.</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gun Shot wound of head</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DUE TO</u> (c) <u>DUE TO</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.) <u>Shot. Self in head with 32 Cal. Pistol.</u>	
20c. TIME OF INJURY Month, Day, Year <u>9:30 PM 4/26 1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) <u>Apartment</u>		20f. (City or town) - (County) (State) <u>Rockville Mont-Md</u>	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-2-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		23d. LOCATION (City or town) (County) (State) <u>Arlington, Virginia</u>	
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. RECEIVED BY REGISTRAR <u>MAY 2 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
05527					05526					
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montg</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i>			c. LENGTH OF STAY IN 1b <i>Life</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Route 1, Gaithersburg, Md</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>at home - Rural</i>					d. STREET ADDRESS <i>Rural</i>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Sanders</i> Last <i>Fulke</i>					4. DATE OF DEATH Month <i>April</i> Day <i>25</i> Year <i>1966</i>					
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 21-1889</i>		9. AGE (in years last birthday) <i>77</i> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>American Ice Co</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Life Insurance</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Montgomery Co., Md</i>			12. CITIZEN OF WHAT COUNTRY? <i>Montgomery</i>			
13. FATHER'S NAME <i>William R. Fulke</i>					14. MOTHER'S MAIDEN NAME <i>Mary Felinda Ward</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>					16. SOCIAL SECURITY NO. <i>578-09-256</i>		17. INFORMANT <i>Henrietta Ashford, 528 Sloop Lane, Andrews, Va</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO <i>Organic dementia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral accident 02-17-63</i> (c) <i>9-16-65</i>								INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs +</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>12-17-</i> , 196 <i>6</i> , to <i>4-25-</i> , 196 <i>6</i> , that (I) (we) last saw the deceased alive on <i>12-24-</i> , 196 <i>6</i> , and that death occurred at <i>6 A</i> M, from the causes and on the date stated above.										
22a. SIGNATURE <i>William C. Miller</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <i>4-25-66</i>		
22c. PHYSICIAN'S NAME (Type) <i>WILLIAM C. MILLER</i>					22d. ADDRESS <i>7 Brook Ave., Gaithersburg, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4-28-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Forest Oak</i>			23d. LOCATION (City, town, County) (State) <i>Gaithersburg, Md.</i>			
24. FUNERAL DIRECTOR <i>Francis H. Barber</i>					ADDRESS <i>Laytonville, Md.</i>		25a. REC'D BY REGISTRAR <i>APR 27 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

W. C. M. R.

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05528

CERTIFICATE OF DEATH

05527

1 PLACE OF DEATH a. COUNTY <u>Eastern</u> <u>Maryland</u> <u>Lat. 39° 26' 9" N. Longitude 76° 34' 17" W.</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>D.C. - FORT BELVOIR</u>		c. LENGTH OF STAY IN 1b <u>41</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>		d. STREET ADDRESS <u>4410-42nd ST N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Eithel GALLOWAY</u>		4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Cauc</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan. 31, 1940</u>
9 AGE (in years last birthday) <u>26</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Navy</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Evansville, Ind.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>GLEN O GALLOWAY</u>	
14. MOTHER'S MAIDEN NAME <u>FREDICKA W LAMBECK</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes 1955-1958</u>	
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT Address <u>Navy records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Transverse laceration of proximal descending aorta with exsanguinating hemorrhage into adjacent viscera.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Aircraft accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>COPIED Hour 0.00 p.m. Apr. 1 1966</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above			
22a. SIGNATURE <u>John F. Russo</u> <u>Pathologist</u> M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>Apr. 8, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>John F. Russo, LT MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-11-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City or town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>W. W. Chambers</u> <u>1400 Chapin St., N. W. Washington, D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 11 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Film L375. 4/11/66 - Dmt.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISWE (5)
SM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 12 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi d. STREET ADDRESS 8505 20th Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Martha Middle Betty Jo Last GEARY						4. DATE OF DEATH Month April Day 23 Year 19 66					
5. SEX Female		6. COLOR OR RACE Cauc		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1930		9. AGE (in years last birthday) 35 yrs.		10. FUNERAL 1 YEAR IF UNDER 24 HRS. Months 1 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.		17. INFORMANT 5, c/o FPO, San Francisco, Calif. CDR Joseph R. Geary, Staff Commander Carrier			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Asphyxiation due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) aspiration of gastric contents. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Deceased vomited and aspirated same.							
20c. TIME OF INJURY Month, Day, Year 2 4-23 1966				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Hospital		20f. (City or town) Bethesda (County) Montgomery (State) Md.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED May 3, 1966			
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR Francis Gasch's Sons, 4739 Baltimore Ave.						ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR MAY 9 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

Film 6576- 5/9/66-
Originally reported on regular death certificate
MB

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05530

CERTIFICATE OF DEATH

05529

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Gaithersburg</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Gaithersburg, Md.</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Andrew Godfrey</u>				4. DATE OF DEATH Month Day Year <u>April 23 1966</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 25, 1882</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10. AGE (In years last birthday) <u>83</u> yrs.		11. IF UNDER 1 YEAR Months Days Hours Min.		12. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Borequard D. Godfrey</u>				14. MOTHER'S MAIDEN NAME <u>Somerville Robinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-09-5108</u>			
17. INFORMANT <u>Family - Mrs. W. A. Godfrey</u>				18. ADDRESS <u>Rt. #2 Gaithersburg Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Tracheo-Bronchitis</u> (c) <u>Fibrosis of Lung Emphysema</u> cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>Benign Hypertrophy of Prostate Gland</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <u>1948</u> to <u>Apr. 23, 1966</u> that (I) (we) last saw the deceased alive on <u>Apr. 24, 1966</u> and that death occurred <u>7:10 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Jack Schumacher</u> M.D.				22b. DATE SIGNED <u>4-25-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Jack Schumacher</u>				22d. ADDRESS <u>Gaithersburg Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 25, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>		23d. LOCATION (City, town or county) (State) <u>Laytonsville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u>				25. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE				25c. ADDRESS			

Montgomery

Malabar

Montgomery

Great Britain

Great Britain

x

William Andrew Cooley April 29 1968

W M

James M. Cooley

James M. Cooley

no

Jack Cooley

James M. Cooley

April 29, 1968

April 29, 1968

James M. Cooley

James M. Cooley

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

Items 10-21 Fill in MARYLAND STATE DEPARTMENT OF HEALTH
05531
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
05530

1. PLACE OF DEATH
a. COUNTY **Montgomery** MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Olney**
c. LENGTH OF STAY IN b **9 hrs.**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Montgomery General Hospital**

2. USUAL RESIDENCE (Where dec. resided, if institution, residence before admission)
a. STATE **Maryland** b. COUNTY **Howard**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Clarksville,**
d. STREET ADDRESS **Tridelpia Rd.**

3. NAME OF DECEASED (Type or print) First Middle Last **Dorothy Virginia Gordon**
4. DATE OF DEATH Month Day Year **April 9 1966**

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **Dec. 16, 1933** 9. AGE (In years last birthday) **32** yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours M.n.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Clerical** 10b. KIND OF BUSINESS OR INDUSTRY **Maryland** 11. BIRTHPLACE (State or foreign country) **USA** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Richard VanSant** 14. MOTHER'S MAIDEN NAME **Sadie Burdette**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. **Medical Records, Olney, Md.** 17. INFORMANT Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Lacerated liver and spleen with secondary**
2161 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) **exsanguination.** DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. **Deceased driving auto when truck collided with it after failing to yield right of way.** 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of this form)
20c. TIME OF INJURY Month, Day Year **4:00 p.m. 4/8 1966** 20d. INJURY OCCURRED While ☒ Not While ☐ at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **Street** 20f. (City or town, County, State) **Rt 216 Howard Md.**

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Belden R. Reap** M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) **BELDEN R. REAP, M.D.** ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED **April 9, 1966**

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **4-12-1966** 22c. NAME OF CEMETERY OR CREMATORY **Linthicum Chapel** 22d. LOCATION (City, town, or country, State) **Clarksville, Md**

23. FUNERAL DIRECTOR ADDRESS **F.C. Higinbotham, Ellicott City, Md** 24a. REC'D BY REGISTRAR **APR 12 1966** 24b. REGISTRAR'S SIGNATURE **Charles Judge**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
05532					05531					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <u>Montgomery</u>					a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					
<u>Silver Spring</u>					<u>Silver Spring</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS					
<u>Holy Cross Hospital of Silver Spring</u>					<u>1030 Lanark Way</u>					
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First <u>Jesse</u> Middle <u>Barton</u> Last <u>Greer</u>					Month <u>4</u> Day <u>16</u> Year <u>1966</u>					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		
<u>Male</u>		<u>White</u>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<u>4/10/02</u>		<u>64</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Director INS DEPT.</u>					<u>AMERICAN FED. OF LABORERS</u>		<u>Tenn.</u>		<u>U.S.</u>	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
<u>C.A. Greer</u>					<u>Sarah Platt</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address		
<u>No</u>			<u>None</u>		<u>Jean Greer</u>			<u>1030 Lanark Way Silver Spring</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> 421 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>THROMBOTIC OCCLUSION OF (R) CORONARY ARTERY</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</u> MEDICAL CERTIFICATION 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
Hour a.m. p.m. 19			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from <u>16 APR 1966</u> to <u>16 APR 1966</u> , that (I) (we) last saw the deceased alive on <u>16 APR 1966</u> and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.										
22a. SIGNATURE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
<u>J.R. Compton</u>					M.O.			<u>16 APR 66</u>		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS					
<u>J.R. COMPTON, MD</u>					<u>612 MAIN ST., LAUREL, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
<u>Burial</u>		<u>11 April, 1966</u>		<u>Hillcrest Memorial Garden Lexington, Ky.</u>						
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>E. Glen Carter 8431 Georgia Ave. Silver Spring, Md.</u>					<u>DATE</u>		<u>APR 22 1966</u>			

CERTIFICATE OF DEATH

05532

05532

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institut on: Residence before admission) a STATE New Jersey b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c LENGTH OF STAY IN 1b 28 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d STREET ADDRESS 12 Clive Hill Road	
3 NAME OF DECEASED (Type or print) First Middle Last Helen Joyce GUBBINGS		4. DATE OF DEATH Month Day Year April 27 19 66	
5 SEX Female	6 COLOR OR RACE Cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Dec. 6 1937
9 AGE (In years last birthday) yrs 28		10 UNDER 1 YEAR Months Days 4 21	11 UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Indiana		12 CIT ZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frances Symes		14. MOTHER'S MAIDEN NAME Eldora Richardson	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO. Unknown	
17 INFORMANT Mr. John S. Gubbings		Address New Jersey 12 Clive Hill Road/	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myelomonocytic Leukemia DUE TO 2042 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (x) (this hospital) attended the deceased from March 30, 19 66 , to April 27, 19 66 , that (x) (we) last saw the deceased alive on April 27, 19 66 , and that death occurred at 1055 A.M. from causes on and on the date stated above.			
22a SIGNATURE Jack C. Zimmerman M.D.		22b. DATE SIGNED 28 April 1966	
22c PHYSICIAN'S NAME (Type) Jack C. Zimmerman		22d ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial-transit	23b DATE THEREOF 4/29/66	23c NAME OF CEMETERY OR CREMATORY Delray Crematory	23d. LOCATION (City or Town) (County) (State) Delray, P. Beach Co. Florida
24 FUNERAL DIRECTOR R. A. Pumphrey Funeral Home, 7557 Wisconsin Ave Bethesda, Maryland		25a REC'D BY REGISTRAR MAY 4 1966	25b. REGISTRAR'S SIGNATURE g Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT

05534

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05533

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

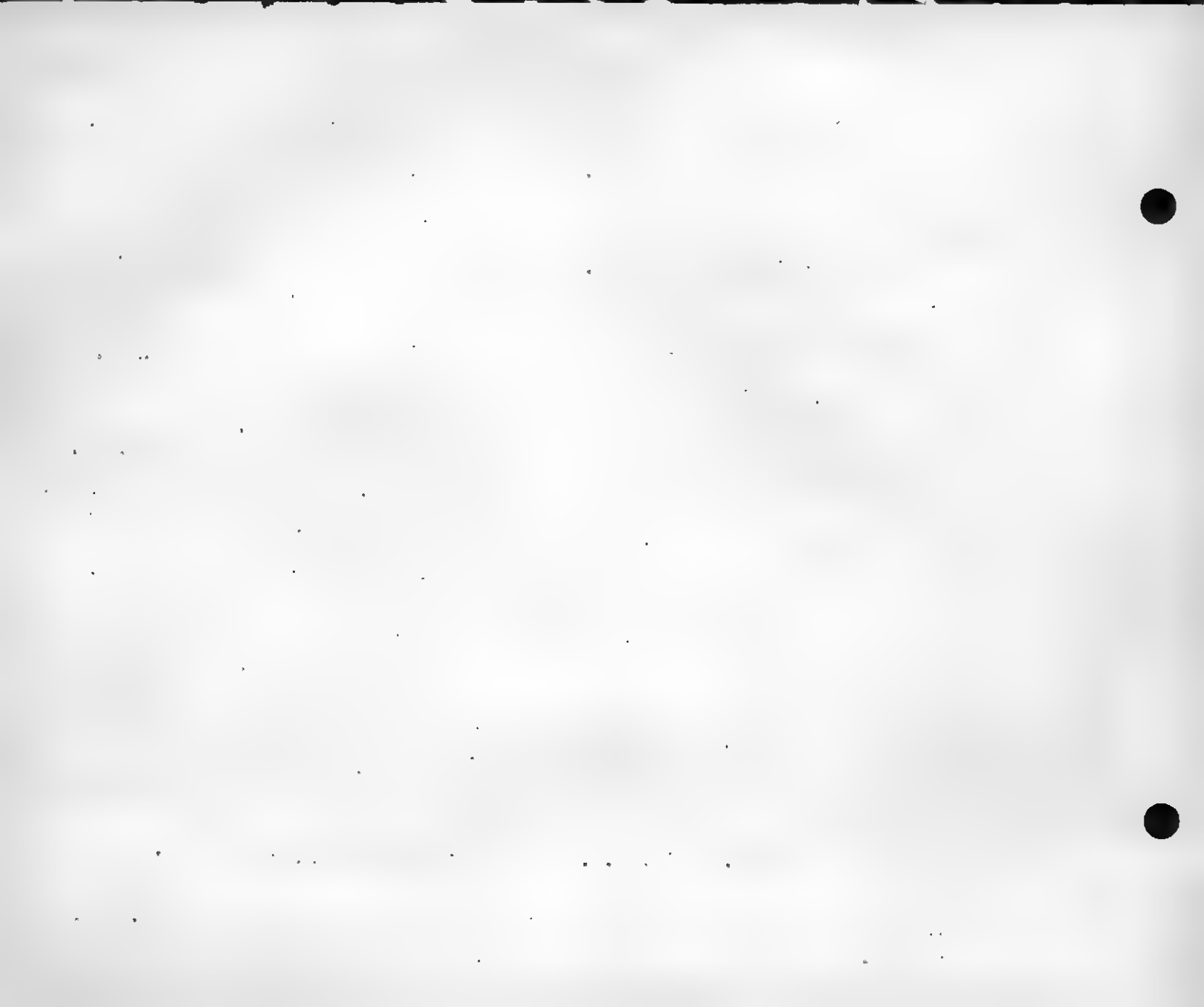
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Takoma Park</u>				c LENGTH OF STAY IN b <u>1 hr + 35 min</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hosp. Tal</u>				d STREET ADDRESS <u>7324 Piney Branch Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Isabelle Olivia Gunther</u>				4. DATE OF DEATH <u>4-18-1966</u>			
5 SEX <u>Female</u>		6 COLOR OR RACE <u>Wh.</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>8-23-1895</u>	
9 AGE (In years last birthday) <u>70</u> yrs.		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Govt Clerk</u>		10b KIND OF BUSINESS OR INDUSTRY		9 IF UNDER 1 YEAR Months Days	
11 BIRTHPLACE (State or foreign country) <u>District of Columbia</u>				12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13 FATHER'S NAME <u>Charles W. Speake</u>				14 MOTHER'S MAIDEN NAME <u>Clara Donn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17 INFORMANT <u>H. Duley - (Nephew)</u> Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201 Acute Coronary Insufficiency</u> DUE TO (b) <u>Hypertensive Cardiovascular Disease.</u> DUE TO (c) <u>Essential Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my op'n on death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Keap, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BELDEN R. KEAP, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>April 18, 1966</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>Apr 21, 1966</u>		23c NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u> <u>Hyattsville, Md.</u>				25c RECEIVED BY REGISTRAR <u>APR 20 1966</u>		25d REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please refile carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> M <div style="display: flex; justify-content: space-between;"> 05533 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND </div> CERTIFICATE OF DEATH 05534 </div>										
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u>			c. LENGTH OF STAY IN 1b <u>9 hrs. 35 min</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery General Hospital</u>					d. STREET ADDRESS <u>Brooke Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Harrison</u> Middle <u>E.</u> Last <u>Hackett</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1966</u>								
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/ /91</u>		9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>unknown</u>					14. MOTHER'S MAIDEN NAME <u>Anna Hackett</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>			16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Montgomery Gen. Hospital records</u> Address <u>Olney, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4501 Digestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Coronary Sclerosis - severe</u> (c) <u>Arteriosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>chronic</u> <u>Yes.</u>		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1964</u> to <u>4/9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/9</u> , 19 <u>66</u> , and that death occurred at <u>9:00</u> M, from the causes and on the date stated above.										
22a. SIGNATURE <u>Donald R. Lewis</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>Donald R. Lewis, M.D.</u>					22d. ADDRESS <u>Medical Center, Sandy Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/14/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>			23d. LOCATION (city, town or county) (State) <u>Sandy Spring, Mo.</u>			
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>					ADDRESS <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

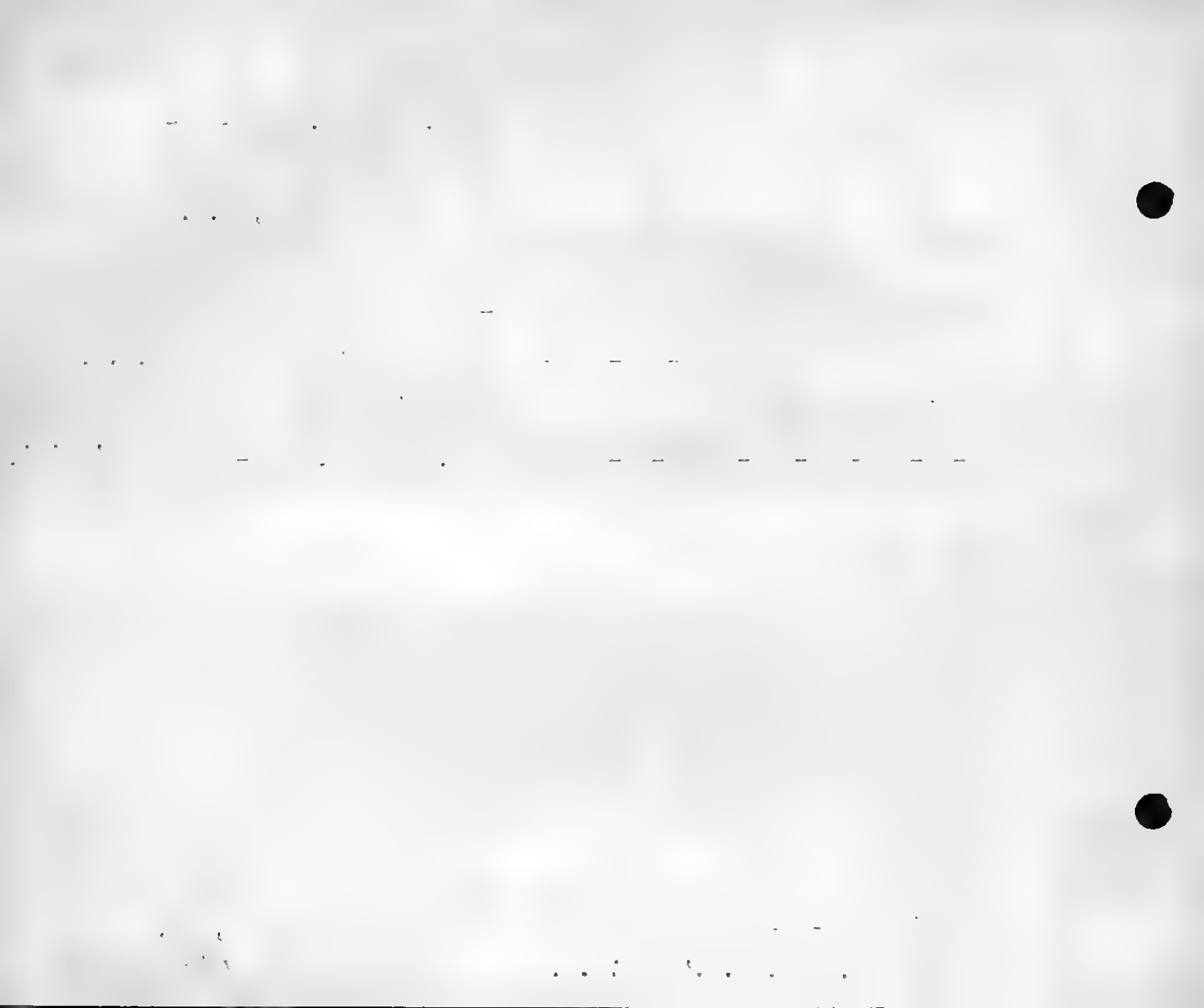
CERTIFICATE OF DEATH

05536

05535

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 2628 Tunlaw Road, N.W.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Sanitarium				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MINNIE		First		Middle P.		Last HAHN	
4. DATE OF DEATH APRIL		Month		Day 19		Year 1966	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-6-1882	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Morrison				14. MOTHER'S MAIDEN NAME Sallie Fugitt			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) - - -				16. SOCIAL SECURITY NO. 265-86-0457		17. INFORMANT Mrs. Ruth Harvey Address Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF STOMACH 151X DUE TO GENERALIZED CARCINOMATOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from APRIL 15 , 1966, to APRIL 19 , 1966, that (I) (we) last saw the deceased alive on APRIL 19 , 1966, and that death occurred at 11:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Henry Lowman</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/19/66	
22c. PHYSICIAN'S NAME (Type) Joseph Gawler's Sons, Inc.				22d. ADDRESS 5130 Wisconsin Ave. N.W. Wash: D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-21-1966		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Suitland, Md.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.				25a. REC'D BY REGISTRAR APR 25 1966			
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05536

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Martinsburg</u>		c. LENGTH OF STAY IN 1b <u>Years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>RFD #2 Dickerson</u>		e. STREET ADDRESS <u>R.F.D. #2 Dickerson</u>	
3 NAME OF DECEASED (Type or print) <u>William T Hamilton</u>		4 DATE OF DEATH <u>April 12 1966</u>	
5 SEX <u>M.</u>	6 COLOR OR RACE <u>colored</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 25 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (in years last birthday) <u>74</u> yrs
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>William T. Hamilton Sr.</u>		14 MOTHER'S MAIDEN NAME <u>Annie Shreves</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes World War I</u>		16 SOCIAL SECURITY NO.	
17 INFORMANT <u>Myrtle Thompson-Ham #2</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute -</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>4201</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL CREMATION, REMAINS <u>18 Apr. 66</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or town) (County) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR <u>Robert L. Sworde</u> ADDRESS <u>Rockville, Md.</u>		25a. REC'D BY REG-STRAR <u>APR 19 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

05538

05537

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE North Carolina b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 11 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS Box 333	
3 NAME OF DECEASED (Type or print) Edward Ronald HANSON		4 DATE OF DEATH Month April Day 10 Year 19 66	
5 SEX Male	6 COLOR OR RACE Cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 6, 1934
9. AGE (In years lost birthday) 31 yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Summers Point, New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Raymond G. Hanson		14. MOTHER'S MAIDEN NAME Dorothy Bollen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO 47 24 7404	
17. INFORMANT Mrs. Carol E. Hanson, 105 Collins Ave./		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral broncho-pneumonia associated with 441X DUE TO septicemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (his hospital) attended the deceased from Mar. 31 , 19 66 , to Apr. 10 , 19 66 , that (X) (we) last saw the deceased alive on Apr. 10 , 19 66 , and that death occurred at 400A M, from causes and on the date stated above.			
22a. SIGNATURE <i>Francis C. Johnson</i> M.D.		22b. DATE SIGNED April 11, 1966	
22c. PHYSICIAN'S NAME (Type) Francis C. Johnson, M. D.		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/12/66	
23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City or Town) (County) (State) Mays Landing, New Jersey	
24. FUNERAL DIRECTOR Washington D. C. W. W. Chambers Co. 1400 Chapin St., N.W.		25. REGISTERED BY REGISTRAR APR 13 1966 DATE	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please file with carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05538											
CERTIFICATE OF DEATH											
Item 2 Film 6376 2/2/66											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney Highland</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery General Hospital</u>						d. STREET ADDRESS <u>Brook Grove Foundation</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Milton</u> Middle <u>Bentley</u> Last <u>Harding</u>			4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1966</u>								
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-17-1880</u>		9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Noah Harding</u>						14. MOTHER'S MAIDEN NAME <u>Helen XXXX Iglehart</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Mrs. Elaine Lynn, 20 Pheasant Drive, Elkridge</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Coronary sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Bronchopneumonia, bilateral</u>										INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u> <u>10 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from <u>July, 1960</u> to <u>4-11-1966</u> , that (II) (we) last saw the deceased alive on <u>4-22-1966</u> , and that death occurred at <u>12:10am</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Charles S. Whitaker, M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-22-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Charles Whitaker</u>						22d. ADDRESS <u>Clarksville, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>4-25-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>			23d. LOCATION (City, town or county) (State) <u>Highland, Md.</u>			
24. FUNERAL DIRECTOR <u>F.C. Higginbotham, Ellicott City, Md</u>						25a. REC'D BY REGISTRAR <u>APR 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05539

05540

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c LENGTH OF STAY in 1b <u>years</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>4905 BERKLEY Street</u>				d STREET ADDRESS <u>4905 BERKLEY Street</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>T</u> Last <u>Harris</u>				4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 1, 1911</u>	
9. AGE (In years, last birthday) <u>55</u>		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>21</u>		11. IF UNDER 24 HRS Hours <u>21</u> Min <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>ARKANSAS</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Julius A. Teller</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA Rumbaugh</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>---</u>		17. INFORMANT <u>Reed Harris - 4905 Berkley St, Cherry Chase, Md.</u>			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Drug Poisoning</u> 4/1/66 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Mental Depression</u> DUE TO (c) <u></u>						INTERVAL BETWEEN DEATH AND DEATH <u>341</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Took over dose of drugs</u>					
20c. TIME OF INJURY Month, Day, Year <u>11:30 PM 4 22 1966</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Cherry Chase Mont Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4/23/66</u> 22. DATE SIGNED			
Address (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL, etc. <u>Cremation</u>		23b. DATE THEREOF <u>4/25/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Geo. Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Md.</u>		25a. RECEIVED BY REGISTRAR <u>APR 26 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>John G. Ball</u>			

<div style="display: flex; justify-content: space-between;"> <div> <div style="text-align: center;"> <div style="font-size: 1.2em; font-weight: bold;">05541</div> <div style="font-size: 0.8em;">DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> <div style="text-align: center;"> <div style="font-size: 1.2em; font-weight: bold;">05540</div> <div style="font-size: 0.8em;">MARYLAND STATE DEPARTMENT OF HEALTH</div> </div> </div> <div style="text-align: center; font-weight: bold; font-size: 1.1em;"> CERTIFICATE OF DEATH </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b <u>3 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> d. STREET ADDRESS <u>3411 University Blvd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edith J. Harrison</u>			4. DATE OF DEATH Month Day Year <u>April 22 1966</u>		5. SEX <u>F</u>			6. COLOR OR RACE <u>Wh</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>1-13-41</u>			9. AGE (in years last birthday) <u>25 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min. _____		IF UNDER 24 HRS. Hours Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Porter</u>			14. MOTHER'S MAIDEN NAME <u>Leona Dorothy Reaves</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>213-38-4250</u>		17. INFORMANT <u>3411 University Blvd</u> <u>Mr. Paul Harrison Kensington, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinoma</u> OUE TO (b) <u>Mammary carcinoma</u> OUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 19____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>65</u> , to <u>April 22</u> , 19 <u>66</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>April 22</u> 19 <u>66</u> , and that death occurred at <u>1:20 PM</u> , from the causes and on the date stated above.		
22a. SIGNATURE <u>Harry N. Carlton</u>					22b. DATE SIGNED _____		22c. PHYSICIAN'S NAME (Type) <u>HARRY N. CARLTON</u>				
22d. ADDRESS <u>909 Reskin Dr. Silver Spring, Md</u>					23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						
23b. DATE THEREOF <u>4/25/66</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Sunshine Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Sunshine, Maryland</u>			24. FUNERAL DIRECTOR ADDRESS <u>Robert A. Pumphrey Bethesda, Md.</u>		
25a. REC'D BY REGISTRAR <u>APR 26 1966</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 - Cleared with Medical Examiner, Dr. [unclear] - [unclear]

MONTGOMERY											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05542											
05541											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			c. LENGTH OF STAY IN 1b <u>5 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			d. STREET ADDRESS <u>8800 - 2ND AVE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8800 - 2ND AVE</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>HARRISON</u> Last <u>HARRISON</u>			4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1966</u>								
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-5-95</u>		9. AGE (In years last birthday) <u>70</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing Supplies</u>		11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>			12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <u>DAVID POLINOFKY</u>					14. MOTHER'S MAIDEN NAME <u>EDITH</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS Edith Adler</u>			Address <u>SHINE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS & MYOCARDIAL INFARCT</u> 421 DUE TO (b) <u>CORONARY ATHEROSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL THROMBOSIS</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>YEARS</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>54</u> , to <u>April 28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>April 28</u> , 19 <u>66</u> , and that death occurred at <u>1:25 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Shamuel A. Sisker</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>April 28 '66</u>				
22c. PHYSICIAN'S NAME (Type) <u>MAURICE A. SISLER</u>					22d. ADDRESS <u>1712 9th St NW</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 29, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bnai Israel Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Orion Md.</u>				
24. FUNERAL DIRECTOR <u>B. Naugan</u>					ADDRESS <u>3501-14th St NW Wash DC</u>		25a. REC'D BY REGISTRAR <u>APR 29 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



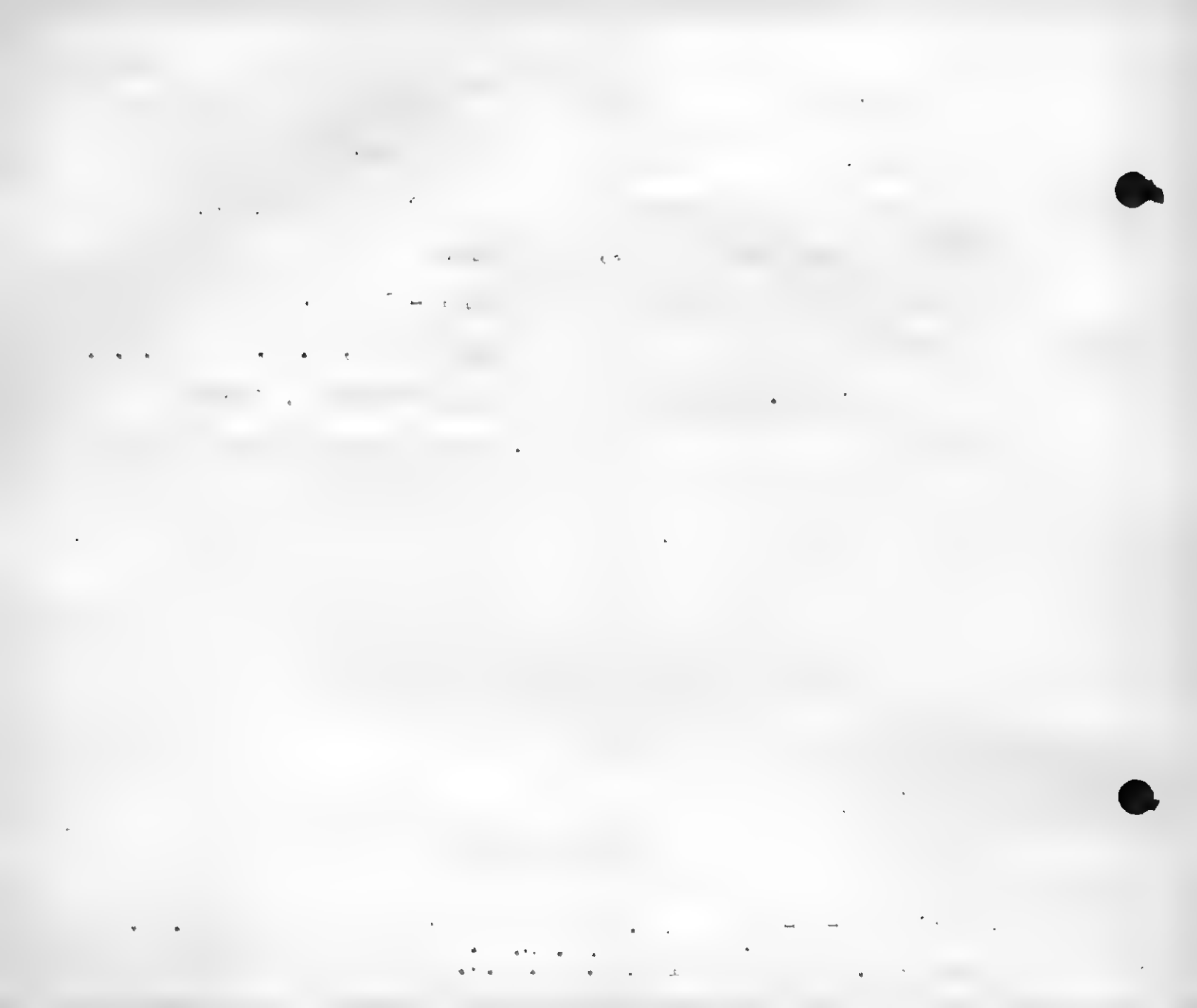
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05542

05543

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. LENGTH OF STAY IN 1b 6 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4405 GLENRIDGE STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARGARET Middle A, Last HARRISON				4. DATE OF DEATH Month 4 Day 27 Year 1966			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 14-81	
9. AGE (In years last birthday) 85		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WILLIAM E. DRALEY				14. MOTHER'S MAIDEN NAME MARGARET A. BROWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. INFORMANT Address MRS. DORIS KIRKLAND SAME as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Generalized arteriosclerosis DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 2 years 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1961 , 19____, to 4/26 , 19____, that I last saw the deceased alive on 4/26/66 , 19____, and that death occurred at 7:25 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9400 Conn. Ave., Kensington, Md DATE SIGNED 4/27/66							
ACTUAL SIGNATURE John E. Everett M.D. 9400 Conn. Ave., Kensington, Md				DATE SIGNED 4/27/66			
PHYSICIAN'S NAME (Type) JOHN E. EVERETT							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-30-66		22c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins ADDRESS WASH. D. C.				24a. REC'D BY REGISTRAR APR 29 1966		24b. REGISTRAR'S SIGNATURE Charles Judge	



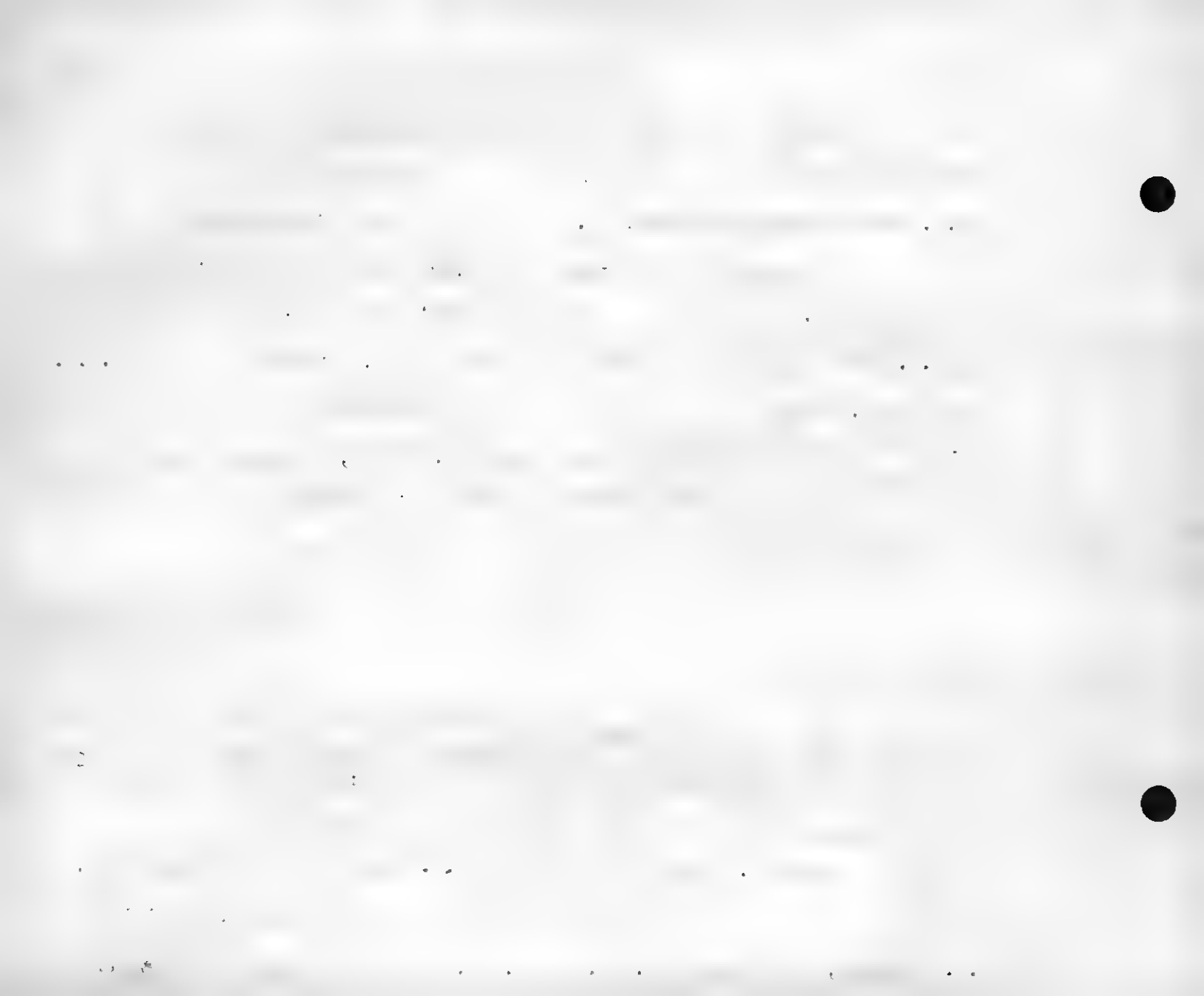
CERTIFICATE OF DEATH

05543

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Florida b. COUNTY MONROE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY in lb 22 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital Bethesda, Md.		e. STREET ADDRESS 1193-A Gilmore Drive	
3. NAME OF DECEASED (Type or print) First James Middle Edward Last HARROD		4. DATE OF DEATH Month April Day 24 Year 1966	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 DEC 1923
9. AGE (In years last birthday) yrs 42		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY NA	
11. BIRTHPLACE (County & State or foreign country) Black Ford, Kentucky		12. CIT. ZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. HARROD		14. MOTHER'S MAIDEN NAME Vernie CRAWELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES NOV45 - APR66		16. SOCIAL SECURITY NO. 406 16 1564	
17. INFORMANT Agnes M. HARROD,		Address Same as Item #2	
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchogenic carcinoma with metastases DUE TO 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NA		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) NA	
20c. TIME OF INJURY Month, Day, Year Hour a.m. NA p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> NA	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NA		20f. (City or town) (County) (State) NA	
21. I certify that he (this hospital) attended the deceased from 1 APRIL , 1966, to 24 APRIL , 1966, that we (we) last saw the deceased alive on 24 APRIL , 1966, and that death occurred at 7:00 a.m. from causes and on the date stated above.			
22a. SIGNATURE <i>James L. Shumaker</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JAMES L. SHUMAKER		22d. ADDRESS U.S. Naval Hospital Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/27/1966	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR W.W. CHAMBERS, 1400 Chapin St. NW., Wash. DC.		25a. REC'D BY REGISTRAR APR 28 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

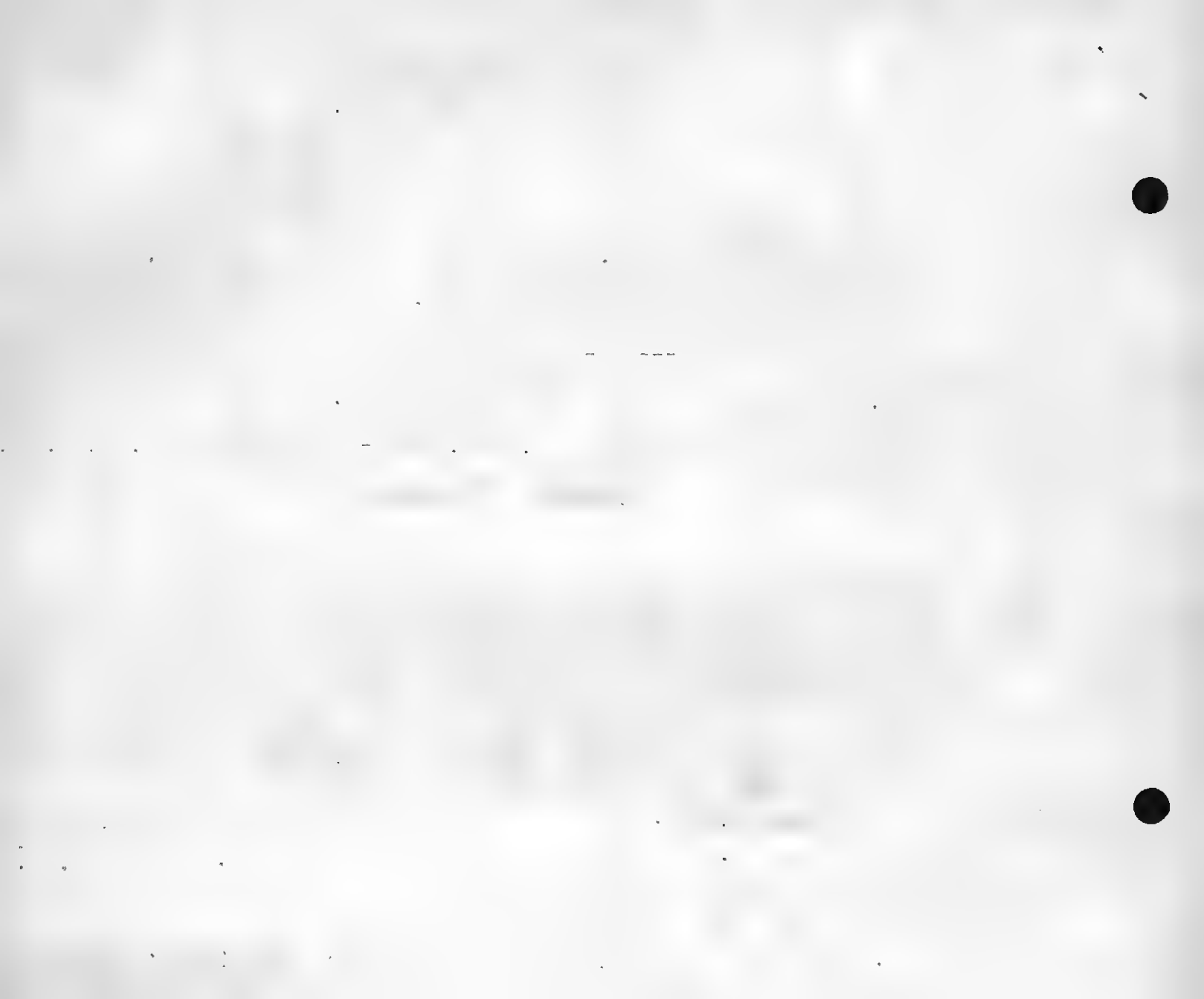


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Coroner notified and approved

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05545											
CERTIFICATE OF DEATH											
Item 12 File 3776 3/5/66 mh 05544											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, d. STREET ADDRESS 400 Lamberton Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First ALICE Middle V. Last HAUCK						4. DATE OF DEATH Month April Day 21 Year 1966					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 24, 1906		9. AGE (In years last birthday) 59 yrs.		10. FUNERAL 1 YEAR 10 Months 27 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) England			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John H. White						14. MOTHER'S MAIDEN NAME Katherine H. White					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Husband John J. Hauck-400 Lamberton Dr. Sil. Sp. Md.				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Cirrhosis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 yrs								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 3, 1962 to Apr 21, 1966 , that (I) (we) last saw the deceased alive on Apr 21, 1966 , and that death occurred at 4:55 AM , from the causes and on the date stated above.											
22a. SIGNATURE Arthur H. Lewis						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-21-66			
22c. PHYSICIAN'S NAME (Type) ARTHUR H. LEWIS						22d. ADDRESS 1733 - N Street, N. W., Washington, D. C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4/25/1966		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery			23d. LOCATION (City, town or county) (State) Rockville Maryland			
24. FUNERAL DIRECTOR Robert A. Pumphrey Bethesda, Maryland						25a. REC'D BY REGISTRAR APR 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

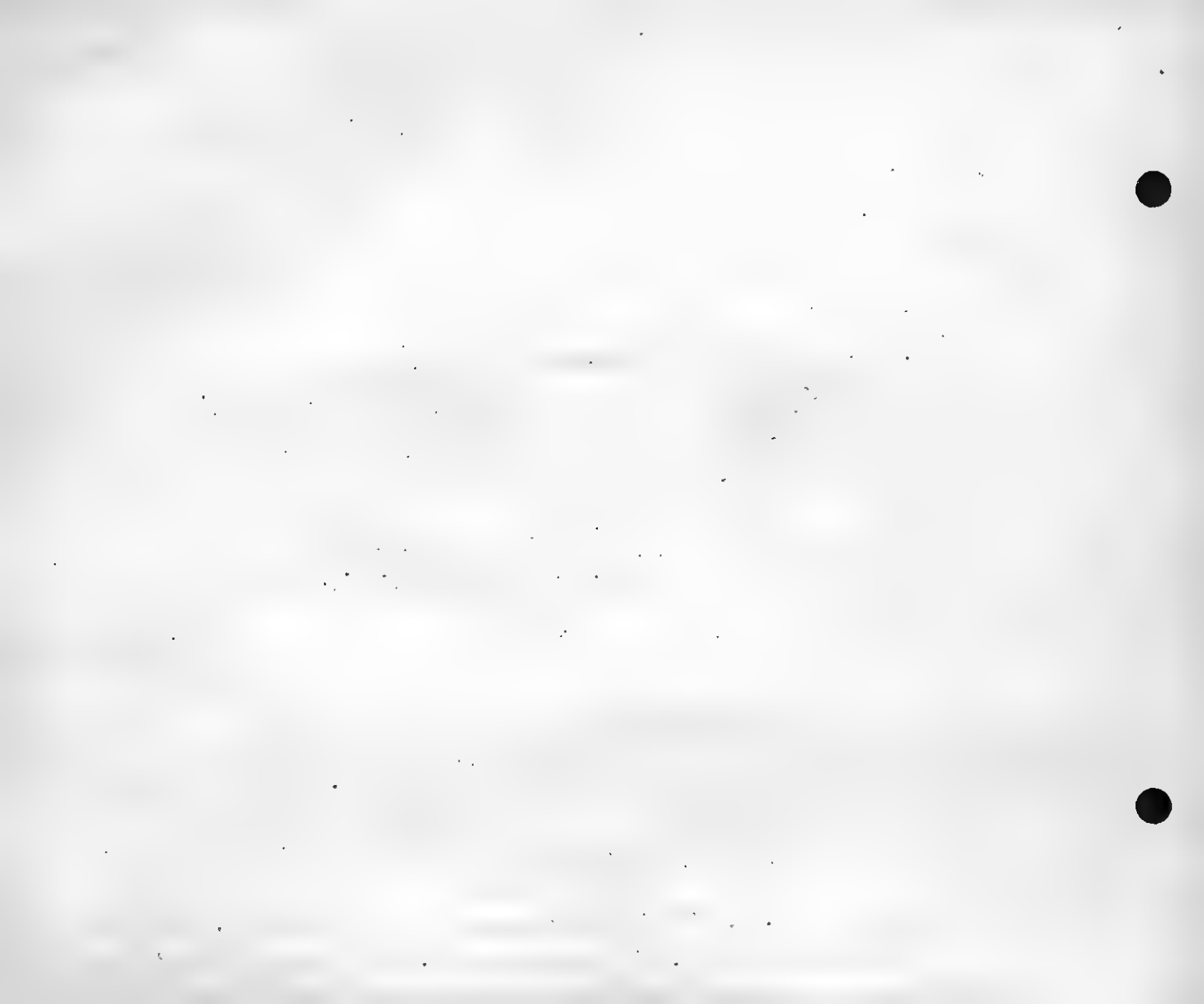
1 & 21 Film G578 67 MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05546 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05545											
1 PLACE OF DEATH a COUNTY Montgomery MARYLAND						2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE Maryland b COUNTY Montgomery					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c LENGTH OF STAY IN 1b 10 days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital						d STREET ADDRESS 4406 Hallett Street				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Christopher Brian Hayes						4 DATE OF DEATH Month Day Year April 17 1966					
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 4-7-66		9 AGE (In years lost birthday) 0 yrs		IF UNDER 1 YEAR Months Days Hours Min 10	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b KIND OF BUSINESS OR INDUSTRY None		11 BIRTHPLACE (State or foreign country) Maryland			12 CITIZEN OF WHAT COUNTRY? U.S.A.		
13 FATHER'S NAME Daniel Alfred Hayes						14 MOTHER'S MAIDEN NAME Roseann. M. DeLoach Laho chue					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16 SOCIAL SECURITY NO None		17 INFORMANT Address Daniel A. Hayes, 4406 Hallett St., S. S., Md					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral interstitial pneumonitis of DUE TO probable viral origin. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap M.D. EXAMINER'S NAME (Type) BELDEN R. REAP M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)					
22. DATE SIGNED April 18, 1966											
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY				23d LOCATED ON (City or town) (County) (State)			
Burial		20 April 1966		Gate of Heaven				A Silver Spring, Maryland			
24 FUNERAL DIRECTOR Barbara E. Humphrey, Inc.						ADDRESS 8434 Denzies Avenue		25a REC'D BY REGISTRAR APR 21 1966		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
05547 CERTIFICATE OF DEATH 05546														
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN ID <i>72 days</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitarium and Hospital</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>1</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i> d. STREET ADDRESS <i>3835 Hamilton Street</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <i>Clifton Ellis Haynes</i>			4. DATE OF DEATH Month <i>April</i> Day <i>7</i> Year <i>1966</i>		5. SEX <i>Male</i>									
6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>August 8, 1900</i>		9. AGE (in years last birthday) <i>65 yrs.</i>		10. IF UNDER 1 YEAR (If under 24 HRS. Months Days Hours Min.)						
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cab driver</i>			11b. KIND OF BUSINESS OR INDUSTRY <i>Chauffeur</i>		12. BIRTHPLACE (County & State, or foreign country) <i>Ohio</i>		13. CITIZEN OF WHAT COUNTRY? <i>United States</i>							
14. FATHER'S NAME <i>Frank Haynes</i>					15. MOTHER'S MAIDEN NAME <i>Grace Fairchild</i>									
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			17. SOCIAL SECURITY NO. <i>225-07-6626</i>		18. INFORMANT <i>Hospital Record</i>			Address						
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MYOCARDIAL FAILURE</i> 421 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>MYOCARDIAL INFARCTION</i> <i>CORONARY OCCLUSION</i> DUE TO (c) <i>ARTERIOSCLEROTIC HEART DISEASE</i> <i>HYPERTENSIVE HEART DISEASE</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 DAYS</i> <i>3 MONTHS</i> <i>2 YEARS</i> <i>8 YEARS</i>														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>CHRONIC PYELONEPHRITIS - RENAL INSUFFICIENCY</i>														
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Baltimore</i>		(County) (State)						
21. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>53</i> , to <i>April 7</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>April 6</i> , 19 <i>66</i> , and that death occurred at <i>12:45</i> PM, from the causes and on the date stated above.														
22a. SIGNATURE <i>Robert L. Krichmar</i>					22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) <i>ROBERT L. KRICHMAR MD</i>					22d. ADDRESS <i>7733 ASAKA AVENUE NW WASHINGTON DC 20012</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Apr. 8, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hebrew Friendship</i>		23d. LOCATION (City, town or county) <i>Baltimore, Maryland</i>		(State)						
24. FUNERAL DIRECTOR <i>Sol Levinson & Bros. 6010 Reisterstown Rd.</i>					25a. REC'D BY REGISTRAR <i>APR 12 1966</i>					25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

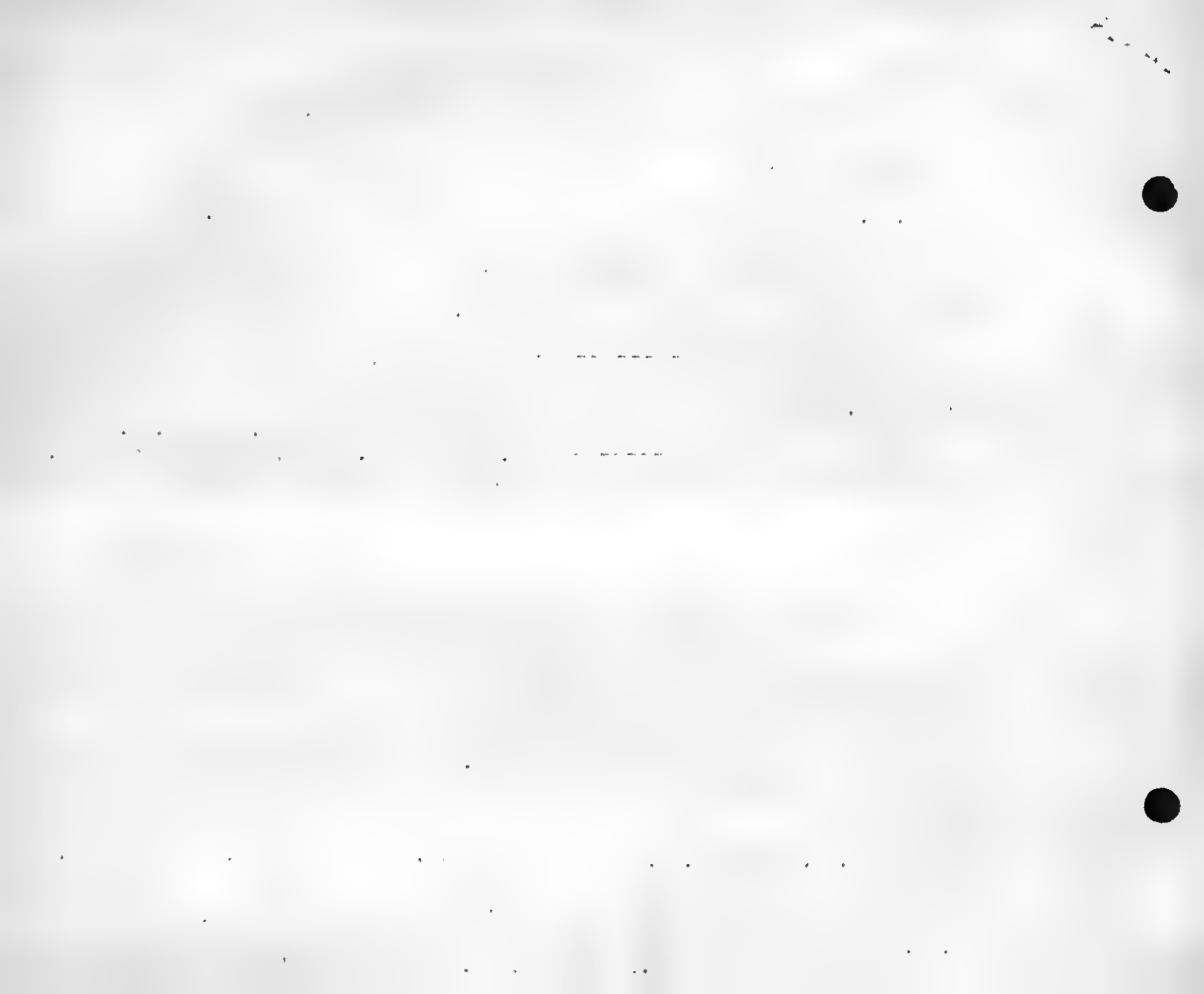
CERTIFICATE OF DEATH

05541

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Rhode Island b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 270 Montgomery Ave.	
3 NAME OF DECEASED (Type or print) First Middle Last Shirley Elaine HENRY		4 DATE OF DEATH Month Day Year April 20 1966	
5 SEX Female	6 COLOR OR RACE Cauc	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 6, 1956
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY	9 AGE (In years last birthday) yrs 9
11 BIRTHPLACE (County & State, or foreign country) Wickford, Rhode Island		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Charlton J. Henry		14. MOTHER'S MAIDEN NAME Geneva Marsh	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO. -----	
17 INFORMANT Mr. Charlton J. Henry, 270 Montgomery Ave./		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. 7540 Congenital heart disease, tetralogy of fallot IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that at (this hospital) attended the deceased from Apr. 11 , 19 66 to April 20 , 19 66 that it (we) lost saw the deceased alive on April 20 , 19 66 , and that death occurred at 1245 M. from causes and on the date stated above			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED April 21, 1966	
22c. PHYSICIAN'S NAME (Type) J. I. Lynch, M. D.		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, or other disposition Buried	23b. DATE THEREOF 4-23-66	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Virginia	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR R. A. Humphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Md.		25a. REC'D BY REGISTRAR APR 25 1966	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>✓</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>					
c. LENGTH OF STAY IN 1b <u>2 years</u>						d. STREET ADDRESS <u>3534 S. Street</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fairoaks</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>EVA</u> Middle <u>V.</u> Last <u>HETH</u>						4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1966</u>					
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 19, 1869</u>		9. AGE (In years last birthday) <u>96</u> yrs.		10. UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Richmond, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert Heth</u>						14. MOTHER'S MAIDEN NAME <u>Lucie Mason</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Katherine Dunscomb</u> Address <u>240 E. Tropical Way, Fla</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intense heart failure</u> 4210 DUE TO (b) <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Myocardial infarction</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/27/1965</u> to <u>4/29/1966</u> , that (I) (we) last saw the deceased alive on <u>4/27/1966</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Chas H. M. M. M.</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Chas H. M. M. M.</u>						22d. ADDRESS <u>Washington, DC</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				23b. DATE THEREOF <u>May 4, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Virginia</u>			
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Washington, DC</u>						25a. REC'D BY REGISTRAR <u>MAY 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05550

05549

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jakob Park</u> c. LENGTH OF STAY IN It <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cedar Haven Rest Home</u> e. ADDRESS <u>7300 Baltimore Avenue</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>6708-4th Street N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WILBUR</u>		4. DATE OF DEATH <u>April 24, 1966</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>April 9, 1894</u> 9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u> 11. BIRTHPLACE (County & State, or foreign country) <u>New York, New York</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Frank Hildebrand</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth Ross</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>578.07.518</u> 17. INFORMANT <u>Same as #2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Cerebral vascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Arteriosclerosis, gen.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>10 yrs. ?</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER!) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May, 1964</u> to <u>April 24, 1966</u>, that (I) (we) last saw the deceased alive on <u>Apr. 24, 1966</u>, and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Philip H. Varner</u> 22c. PHYSICIAN'S NAME (Type) <u>PHILIP H. VARNER</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>16636 Georgia Ave., Wheaton, Md.</u>		22b. DATE SIGNED <u>4/24/66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 30, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>			
23d. LOCATION (City, town or county) <u>Colmar Manor, Md.</u>		23e. LOCATION (State) <u>Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>			
24a. ADDRESS <u>254 Carroll St. N.W.</u>		24b. CITY <u>Washington, D.C.</u>		25. REC'D BY REGISTRAR <u>APR 27 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		26.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 13, 14 Film 8376 5/5/66 mh

05551

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

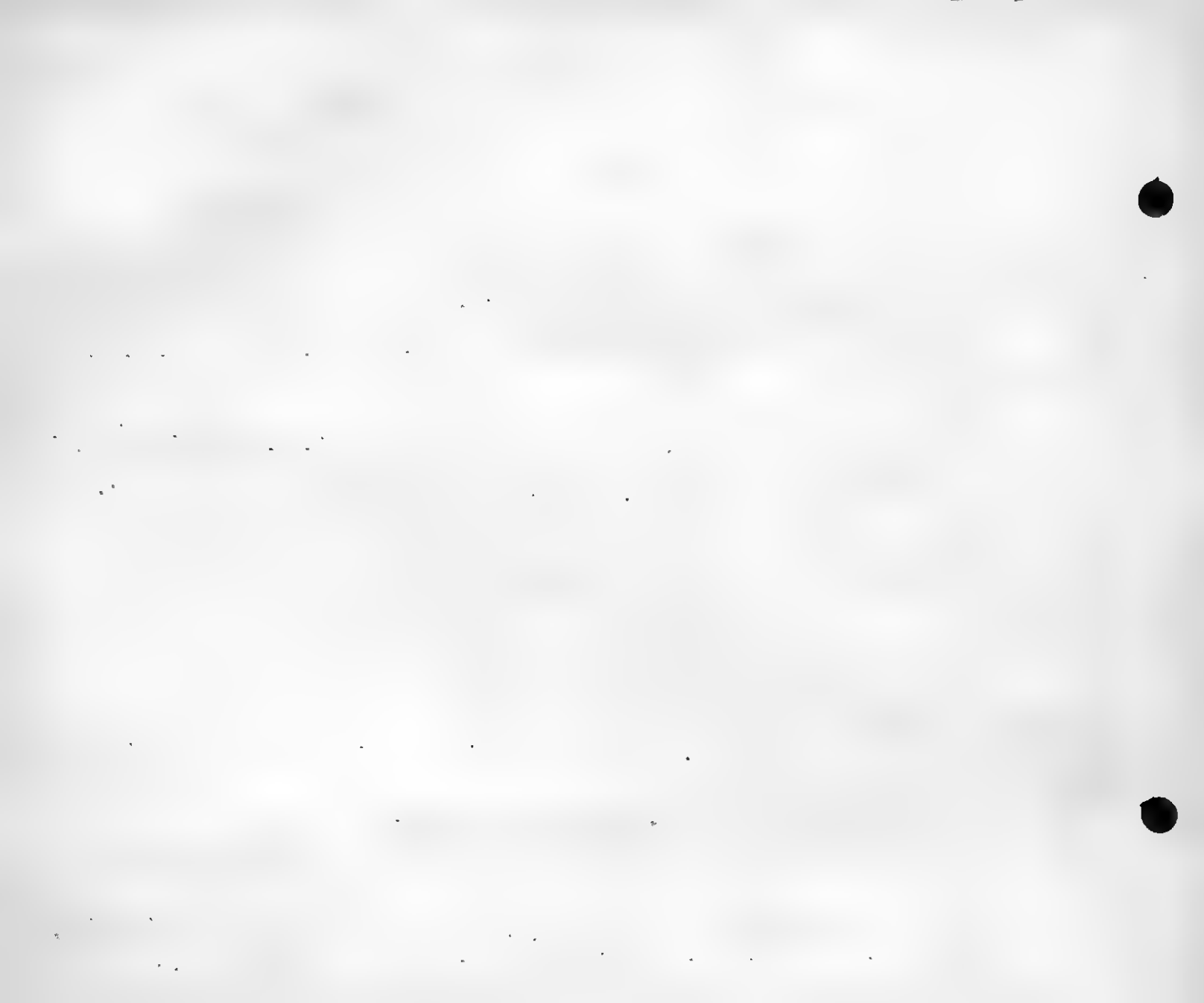
05551

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 5 Hours		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Silver Spring, Maryland	
3. NAME OF DECEASED (Type or print) Susie Hilderbrand		4. DATE OF DEATH Month 4 Day 15 Year 1966	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10/20/1938
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Texas
13 FATHER'S NAME Ed Hollis		14 MOTHER'S MAIDEN NAME Susie Sims	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO None	17 INFORMANT Walter Hilderbrand Address 11632 Lockwood Drive Silver Spring, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Hemorrhage Intraabdominal. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Gun Shot-Wound of Abdomen. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 hr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Shot-Self - 22 cal Pistol -		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 8:30 pm 4/14 1966	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) Home	20f. (City or town) (County) (State) Silver Spring Mont. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John H. Ball EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 4/15/66			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 19 April 1966	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City or Town) (County) (State) Rockville, Maryland
24 FUNERAL DIRECTOR Charles Judge Address 11220 E. Pumphrey, Inc. Silver Spring, Md.		25. RECEIVED BY REGISTRAR APR 22 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
05552													
05551													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>							
c. LENGTH OF STAY IN 1b <u>1 year</u>						d. STREET ADDRESS <u>9039 Sligo Creek Parkway</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9039 Sligo Creek Parkway</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u></u> Last <u>Knot</u>						4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1966</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 6, 1929</u>		9. AGE (In years last birthday) <u>36</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dist. telegraph</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Reading, Penna.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Joseph Knot</u>						14. MOTHER'S MAIDEN NAME <u>Anna Shusko</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW II</u>				16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT Address <u>1501 N. 11th St.</u> <u>Gibson & Sanders 7. H. Reading, Penna.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>Anterior Eleventh Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>												INTERVAL BETWEEN ONSET AND DEATH <u>15 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>66</u> to <u>April 24</u> , 19 <u>66</u> ; that (I) (we) last saw the deceased alive on <u>April 24</u> , 19 <u>66</u> , and that death occurred at <u>8:20</u> A.M. from the causes and on the date stated above.													
22a. SIGNATURE <u>Joseph E. Patten</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/25/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>HAROLD E. KATTEK</u>						22d. ADDRESS <u>1407 Woodland Parkway</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>28 April 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Exeter, Berks Co., Pa.</u>					
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>						ADDRESS <u>8434 Georgia Avenue</u>		25a. REC'D BY REGISTRAR <u>APR 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

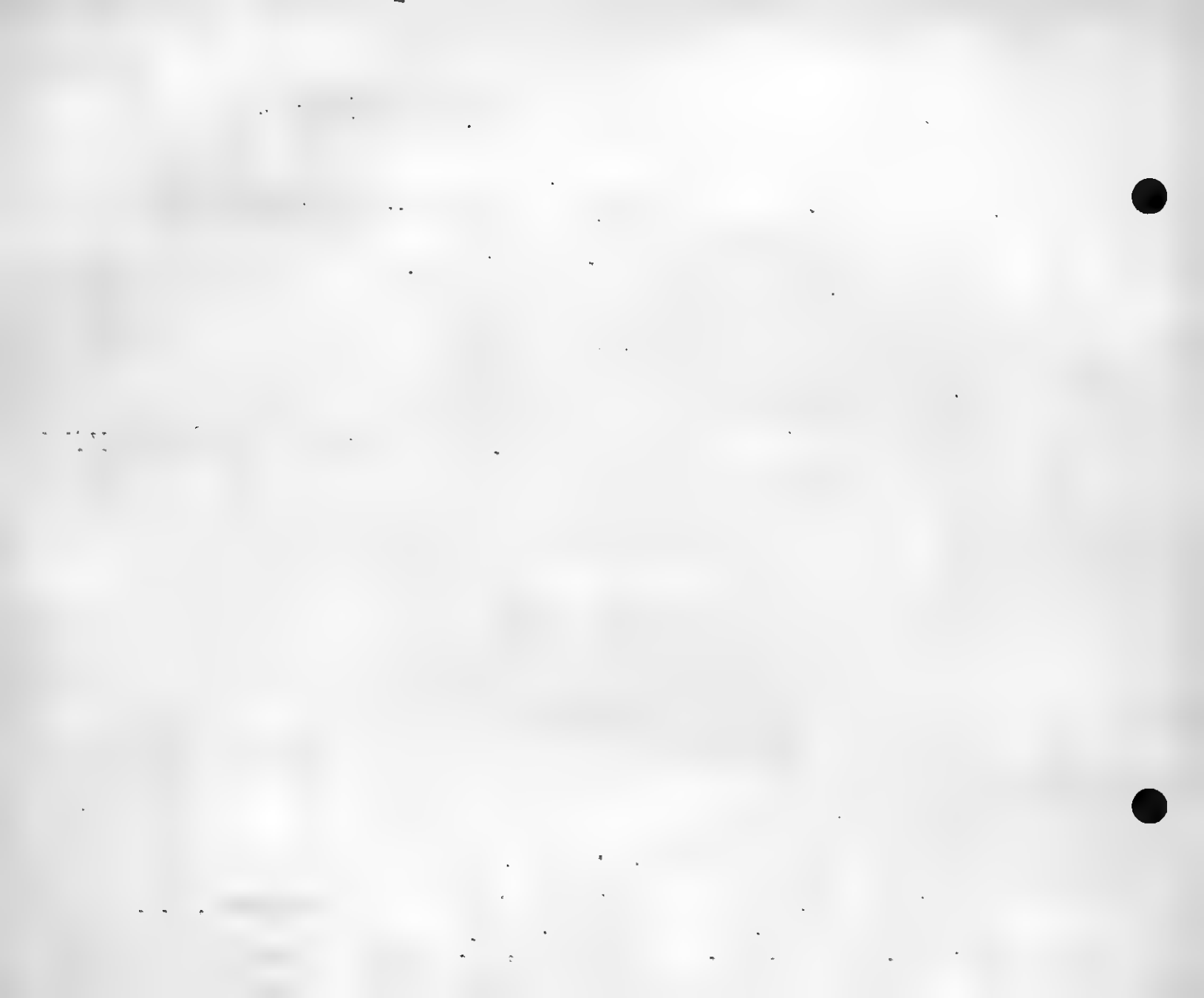
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05553

05552

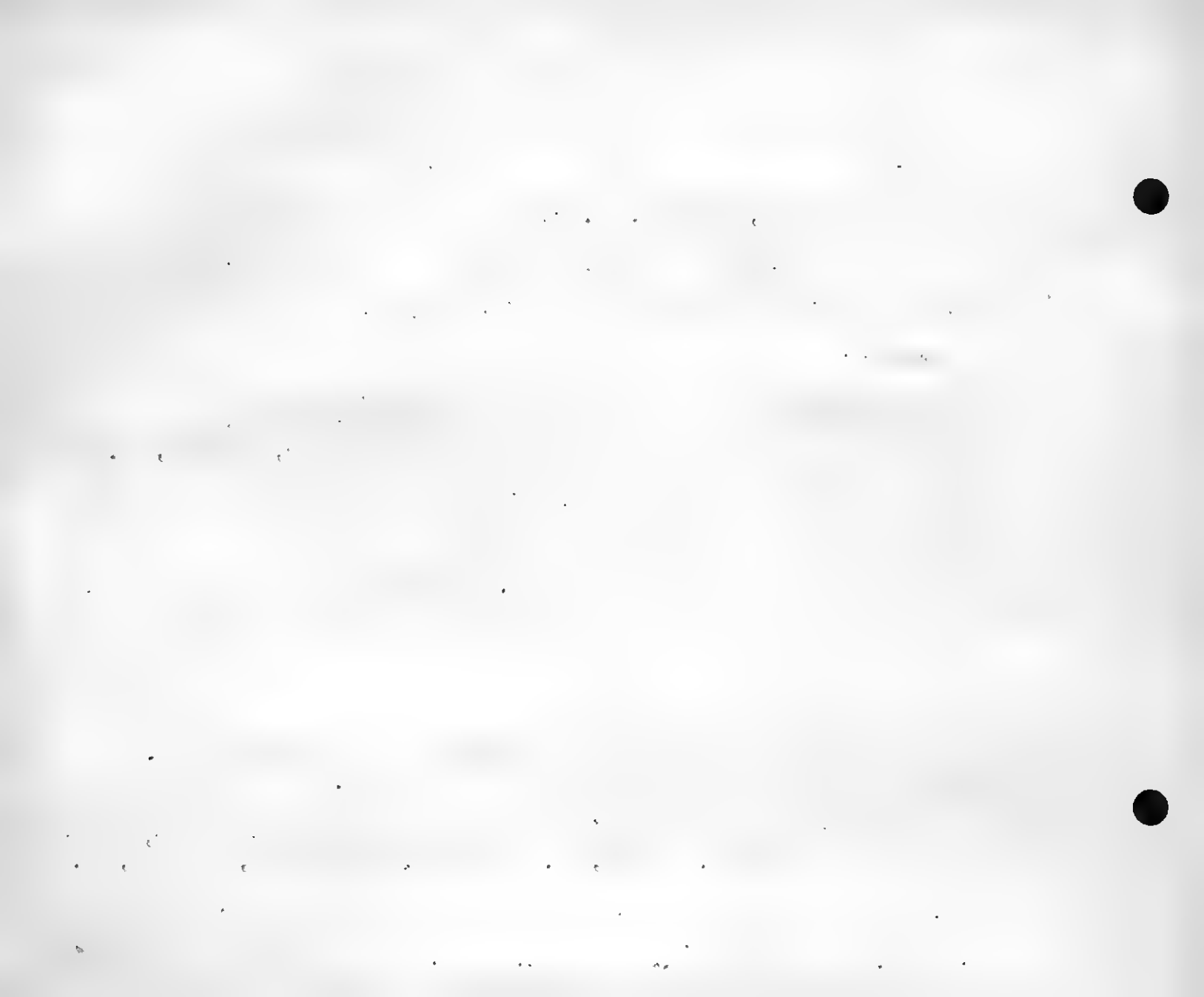
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN ID <i>10 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Montgomery Convalescent Home</i>		d. STREET ADDRESS <i>839 Richmond Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Elizabeth</i>		4. DATE OF DEATH Month <i>April</i> Day <i>29</i> Year <i>1966</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>11/11/1878</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jacob Franz</i>		14. MOTHER'S MAIDEN NAME <i>Eleanor Reuter</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war & dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mr. Elliott Spicer</i>		Address <i>7119 9th St. N.W. Washington, D.C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Embolus</i> DUE TO (b) <i>Generalized Arteriosclerosis</i> DUE TO (c) <i>Diabetes mellitus @ Carcinoma Breast</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>8-10 yrs</i>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>2/14</i> , 19 <i>47</i> , to <i>4/29</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>4/28</i> , 19 <i>66</i> , and that death occurred at <i>4:40 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>W. B. Wardrop MD</i>		22b. DATE SIGNED <i>4/29/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>W. B. WARDROP MD</i>		22d. ADDRESS <i>808 Pershing Dr. Silver Spring Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 2, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Washington, D.C.</i>	
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>MAY 5 1966</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New York b. COUNTY Bronx						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					c. LENGTH OF STAY IN 1b 2 days						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Sadie Middle (None) Last Horwitz			4. DATE OF DEATH Month April Day 20 Year 1966								
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 January 1900		9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) New York			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Leon Statman					14. MOTHER'S MAIDEN NAME Fanny Wiesen						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. Unascertainable					17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md. 20014	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Bacterial Septicemia 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Left Pleural Empyema DUE TO (c) Metastatic Breast Carcinoma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 2 Days 2 Days 4 Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 18, 1966 , to April 20, 1966 , that he (we) last saw the deceased alive on April 20, 1966 , and that death occurred at 4:30 M, from the causes and on the date stated above.											
22a. SIGNATURE Albert R. Casazza M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 20 April 1966			
22c. PHYSICIAN'S NAME (Type) Albert R. Casazza, MD.						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4/21/66		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery			23d. LOCATION (City, town or county) (State) New York, New York			
24. FUNERAL DIRECTOR Wash., D. C.						25a. REC'D BY REGISTRAR APR 22 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			
B. Danzansky & Sons 3501 14th St., N.W.											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney						c. LENGTH OF STAY IN 1b 4 days					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital						d. STREET ADDRESS 26019 Mt. Vernon Ave.					
3. NAME OF DECEASED (Type or print) First Gora Middle May Last Howes						4. DATE OF DEATH Month April Day 6 Year 1966					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1 1890		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. Wife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles T. Hawkins						14. MOTHER'S MAIDEN NAME Julia Pope					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No						16. SOCIAL SECURITY NO. 211-46-6242		17. INFORMANT Medical Records, Olney, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular-Renal Disease with Cardiac Decompensation and Uremia. DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Terminal Bronchopneumonia										INTERVAL BETWEEN ONSET AND DEATH 10 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) ---							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) this hospital attended the deceased from July 10, 1965 to April 5, 1966 , that (I) was last saw the deceased alive on April 5, 1966 , and that death occurred at 12:12 AM , from the causes and on the date stated above.											
22a. SIGNATURE <i>M. McKendree Boyer</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22c. PHYSICIAN'S NAME (Type) M. McKendree Boyer, M. D. M.M. Boyer						22d. ADDRESS 9701 Church Street Damascus, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4-8-66		23c. NAME OF CEMETERY OR CREMATORY Laytonsville		23d. LOCATION (City, town or county) (State) Laytonsville, Md.			
24. FUNERAL DIRECTOR ADDRESS Francis H. Barber Laytonsville, Md.						25a. REC'D BY REGISTRAR DATE APR 11 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> 14445			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05556

CERTIFICATE OF DEATH

05556

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY IN b. <i>N.B.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		d. STREET ADDRESS <i>10011 Menlo Dr.</i>	
3. NAME OF DECEASED (Type or print) First <i>Brady</i> Middle <i>Brady</i> Last <i>Huntley</i>		4. DATE OF DEATH Month <i>April</i> Day <i>18</i> Year <i>1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/17/66</i>
9. AGE (In years lost birthday) yrs. <i>24</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Newborn</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>Mont. Co. Md.</i>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Sterling Gordon Huntley</i>	
14. MOTHER'S MAIDEN NAME <i>Louis Mae Boyer</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>ASPHYXIA</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>PREMATURITY</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>2 MINUTES</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>4-17</i> , 19 <i>66</i> , to <i>4-18</i> , 19 <i>66</i> that (I) (we) last saw the deceased alive on <i>4-17</i> , 19 <i>66</i> , and that death occurred at <i>3:21</i> AM, from causes and on the date stated above.			
22a. SIGNATURE <i>Robert O. Warthen</i>		22b. DATE SIGNED <i>4-18-66</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL (CREMATION, REMOVAL) (Specify)	23b. DATE THEREOF <i>4/21/66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Suburban Hospital</i>	23d. LOCATION (City or Town) (County) (State) <i>Bethesda - Montgomery Md.</i>
24. FUNERAL DIRECTOR <i>Mrs. Amelia C. Carter</i> Administrator		25a. REC'D BY REGISTRAR DATE <i>APR 22 1966</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 1/65

1 (M)
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05557

05556

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sakima Park</u> c. LENGTH OF STAY IN 1b <u>1 year</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Oakhaven Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chillum</u> d. STREET ADDRESS <u>5810-10th Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>KATHRYN MARIE IRONFIELD</u> First Middle Last		4. DATE OF DEATH <u>April 14</u> 19 <u>66</u> Month Day Year	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-19-1889</u> 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>	11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>
13. FATHER'S NAME <u>James Crilley</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-44-5147</u>	
17. INFORMANT <u>Edward J. Nealon</u>		Address <u>(SAME)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 4200 DUE TO (b) <u>Congestive Heart Failure (Chronic)</u> 6 yrs. Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>Arteriosclerotic Heart Disease</u> 10 yrs.		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/19/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Ft. Myer, Va.</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>		ADDRESS <u>300-4th St. N.E. Wash.</u>	
25a. REC'D BY REGISTRAR <u>APR 19 1966</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
05558									
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>					e. STREET ADDRESS <u>8517 7 Lower Avenue</u>				
3. NAME OF DECEASED (Type or print) First <u>Eugenie</u> Middle <u>(NMN)</u> Last <u>Iseli</u>					4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 4, 1896</u>		9. AGE (In years last birthday) <u>70</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Switzerland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Switzerland</u>		6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME <u>Stalffo</u>					14. MOTHER'S MAIDEN NAME <u>BOZENIA STOFFER</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>220-26-4457B</u>		17. INFORMANT <u>Hospital Records</u> Address <u>7600 Carroll Ave.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure</u> + x 01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> <u>48 hrs</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>July 1956</u> to <u>April 13, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 12, 1966</u> , and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>James M. Whitlock</u>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>4-13-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK</u>					22d. ADDRESS <u>2717 Canaan Takoma Park Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-16-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft LINCOLN CEM</u>		23d. LOCATION (City, town or county) (State) <u>BLADENSBURG MD</u>		25a. REC'D BY REGISTRAR <u>W.W. CHAMBERS</u>	
24. FUNERAL DIRECTOR <u>8655 GAYNE SILVER SPRING MD</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		APR 14 1966		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05559

CERTIFICATE OF DEATH

05558

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>53 Days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				e. STREET ADDRESS <u>8721 Jenifer Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Douglas</u> Middle <u>Herbert</u> Last <u>Jelliman</u>				4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>19 66</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>25 February 1893</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (County & State, or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herbert C. Jelliman</u>				14. MOTHER'S MAIDEN NAME <u>Edith Roberts</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W.1</u>		17. INFORMANT <u>The Medical Records</u> Address <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Possible aspiration, gastric contents</u> 473X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia - Tuberculosis to be ruled out</u> (c) <u>Cachexia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>5 days</u> <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Manic-depressive psychosis, depressive phase</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from <u>9 February, 19 66</u> , to <u>3 April, 19 66</u> that I (we) last saw the deceased alive on <u>3 April 19 66</u> , and that death occurred at <u>9:25M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John M. Davis</u>				ATTENDING PHYS. <input type="checkbox"/> M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>5 April 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>John M. Davis, M.D.</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>April 6, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Catholic Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arundel, Balt. Co., Md.</u>	
24. FUNERAL DIRECTOR <u>John Burns Sons, Towson, Maryland</u>				25a. RECEIVED BY REGISTRAR <u>APR 11 1966</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
055611 07165											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>26 hrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH SANITARIUM + Hospital</u>						d. STREET ADDRESS <u>610 Mississippi Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cecelia</u> Middle <u>Ann</u> Last <u>Johnson</u>						4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/29/96</u>		9. AGE (in years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Wash Cook</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hecht Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>FRANK Margerum</u>						14. MOTHER'S MAIDEN NAME <u>Susanna Cornell</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>				16. SOCIAL SECURITY NO. <u>213-12-1697</u>		17. INFORMANT <u>John H. Johnson</u> Address <u>610 Mississippi Ave., S. S., Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary artery insufficiency</u> DUE TO <u>Acute coronary thrombosis</u> DUE TO <u>Coronary arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>										INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u> <u>30 hours</u> <u>Unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 8</u> , 1948, to <u>April 29</u> , 1966, that (I) (we) last saw the deceased alive on <u>April 29</u> , 1966, and that death occurred at <u>6:57 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Aaron H. Traum</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>April 29, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Aaron H. Traum</u>						22d. ADDRESS <u>5237 Georgia Ave - Silver Spring, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3 May 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Burtonsville, Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Burtonsville, Maryland</u>			
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>						24a. ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE <u>MAY 10 1966</u> <u>Charles Judge</u>			

MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT.

05561

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

115559

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE <u>Washington</u> b COUNTY <u>Washington</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAROMA PARK</u>		c LENGTH OF STAY IN lb <u>3 days 12 hrs</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN & Hosp.</u>		e STREET ADDRESS <u>421. VAN BUREN ST.,</u>	
3. NAME OF DECEASED (Type or print) First <u>JOEL</u> Middle <u>HENDERSON</u> Last <u>JOHNSTON</u>		4. DATE OF DEATH Month <u>4</u> Day <u>11</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-7-05</u>
9 AGE (In years last birthday) <u>60 yrs</u>		10 IF UNDER 1 YEAR Months <u>4</u> Days <u>11</u> Hours <u>19</u> Min. <u>66</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Addressograph operator</u>		10b KIND OF BUSINESS OR INDUSTRY <u>U.S. Senate</u>	
11 BIRTHPLACE (State or foreign country) <u>MISSOURI</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>EMMA THOMASON</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES ARMY WW2</u>		16 SOCIAL SECURITY NO <u>100-1-10000</u>	
17 INFORMANT <u>Hospital Records</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute cerebral edema due to</u> <u>9040</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>bilateral subdural hematoma.</u> DUE TO (c) _____			INTERVA. BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Deceased fell at home, hitting head on night stand.</u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>1:30 PM</u> <u>3/29</u> <u>1966</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office building, etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Washington D. C.</u>	
21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Peep</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. PEEP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>April 11, 1966</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/14/66</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem</u>		23d LOCATION (City or town) (County) (State) <u>Arlington, Virginia</u>	
24 FUNERAL DIRECTOR <u>The S. H. Hines Company</u>		25a REC'D BY REGISTRAR <u>APR 14 1966</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a temporary certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

05562

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

055611

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN ID DOA		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Prince George		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel		d. STREET ADDRESS 1103 Snowden Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First William		Middle Cecil		Last Jones		4. DATE OF DEATH Month April Day 23 Year 1966		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH September 2, 1914		9. AGE (in years last birthday) 51 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Jones	
14. MOTHER'S NAME Lena Moore		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Family & Medical Records, Olney, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 4201 DUE TO (b) Coronary Artery Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. DATE SIGNED 4/23/1966		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-27-66		23c. NAME OF CEMETERY OR CREMATORY Brookside Memorial Park, Middlebrook, Md.		23d. LOCATION (City, town or county) (State)		24. FUNERAL DIRECTOR W. W. Danaher, Laurel Md.		25a. REC'D BY REGISTRAR APR 29 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. CHIEF MEDICAL EXAMINER Belden R. Reap MD		25d. ASSISTANT MEDICAL EXAMINER		25e. DEPUTY MEDICAL EXAMINER		25f. ADDRESS (Street, city, town, or county)		25g. ADDRESS (Street, city, town, or county)		25h. ADDRESS (Street, city, town, or county)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

05563

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

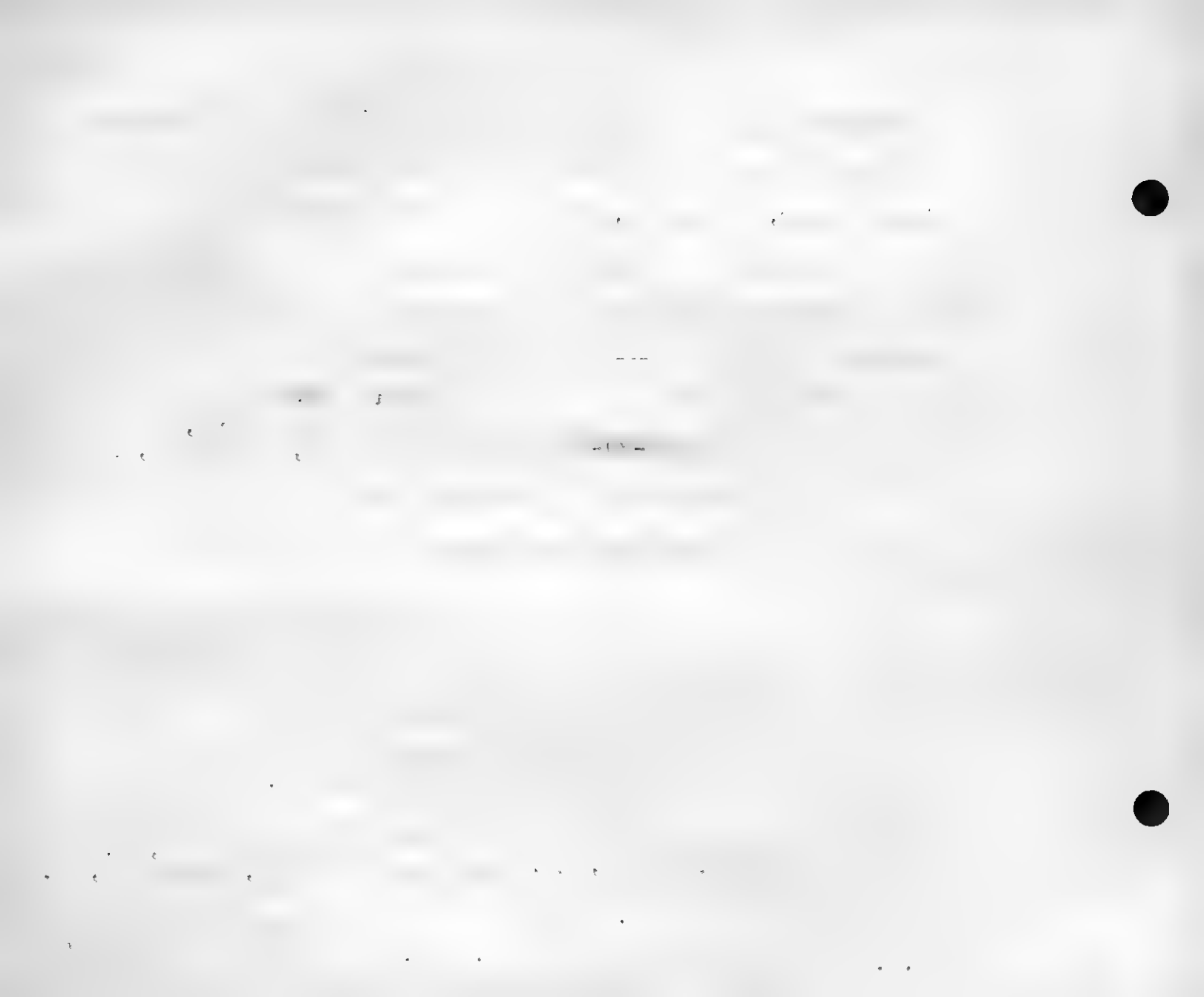
05561

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>1 hr - 2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fairland Nursing Home, 2101 Fairland</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>PENN</u> b. COUNTY <u>1</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PHILADELPHIA</u> 7- d. STREET ADDRESS <u>3111 WEST ARIZONA ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ETHEL</u> Middle <u>KALE</u> Last <u>KALE</u> 4. DATE OF DEATH <u>APRIL 23 1966</u>		5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>3 - - 1888</u> 9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>NATHAN ROSENFELD</u> 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NO</u> 17. INFORMANT <u>DAVID KALE - 1112 CADDINGTON AVE MD</u> Address <u>SILVER SPRING</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease.</u> (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>April 1964</u> to <u>April 1966</u> , that (I) (we) last saw the deceased alive on <u>4/23 1966</u> , and that death occurred at <u>8:15</u> A.M., from the causes and on the date stated above. 22a. SIGNATURE <u>Ira N. Tublin</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>4/23/66</u> 22c. PHYSICIAN'S NAME (Type) <u>Ira N. Tublin</u> 22d. ADDRESS <u>800 Pershing Drive Silver Spring, Maryland</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>4/24/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASH. CEM.</u> 23d. LOCATION (City, town or county) (State) <u>MD.</u>		24. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u> ADDRESS <u>4217 - 9th St</u> 25a. REC'D BY REGISTRAR <u>APR 27 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their office should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 47 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Maryland						d. STREET ADDRESS 10200 Brunett Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary			First Mary Middle (NMN) Last Karafas		4. DATE OF DEATH Month April Day 9 Year 1966				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 August 1916		9. AGE (In years last birthday) 49 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Handlovic					14. MOTHER'S MAIDEN NAME Susan Andrasko				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 186-20-2912		17. INFORMANT The Medical Records, The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis of undetermined etiology 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myelogenous Leukemia DUE TO (c) _____									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that he (this hospital) attended the deceased from 21 February, 1966 , to 9 April, 1966 , that he (we) last saw the deceased alive on 9 April, 1966 , and that death occurred at 10:45 P.M. on the causes and on the date stated above.									
22a. SIGNATURE Alexander Levitan						22b. DATE SIGNED 10 April 1966			
22c. PHYSICIAN'S NAME (Type) Alexander A. Levitan, M.D.						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE THEREOF 4/13/66		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Prince Georges County, Md.		
24. FUNERAL DIRECTOR The S.H. Hines Company						25a. REC'D BY REGISTRAR W. APR 12 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05565

05565

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Belmont Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2735-P St. N.W.</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Philip Kearney</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>12</u> Year <u>1966</u>	
5. SEX <u>M.</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct. 23-1888</u> 9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS.: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>Austin Minnesota</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Kearney</u>		14. MOTHER'S MAIDEN NAME <u>Mat Kearney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>4201</u>		17. INFORMANT <u>Mr. Hugh Jacobson</u> Address <u>2735-P St. N.W.</u> <u>Wash. D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>generalized arteriosclerosis</u> (c) <u>Cancer of stomach & secondary anemia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>19 WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>			
20c. TIME OF INJURY Month, Day, Year <u>1966</u> Hour a.m. <u>4-9</u> p.m. <u>4-9</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>BURTONSVILLE, M.D.</u>		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>4-9</u> 19 <u>66</u> to <u>4-12</u> 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>4-9</u> 19 <u>66</u> and that death occurred at <u>330 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>John R. Spencer</u> M.D.		22b. DATE SIGNED <u>4-12-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John R. Spencer</u>		22d. ADDRESS <u>BURTONSVILLE, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>April 15-1966</u>		23b. DATE THEREOF <u>April 15-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		23d. LOCATION (City, town, or county) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Kellers</u>		25a. REC'D BY REGISTRAR <u>APR 15 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

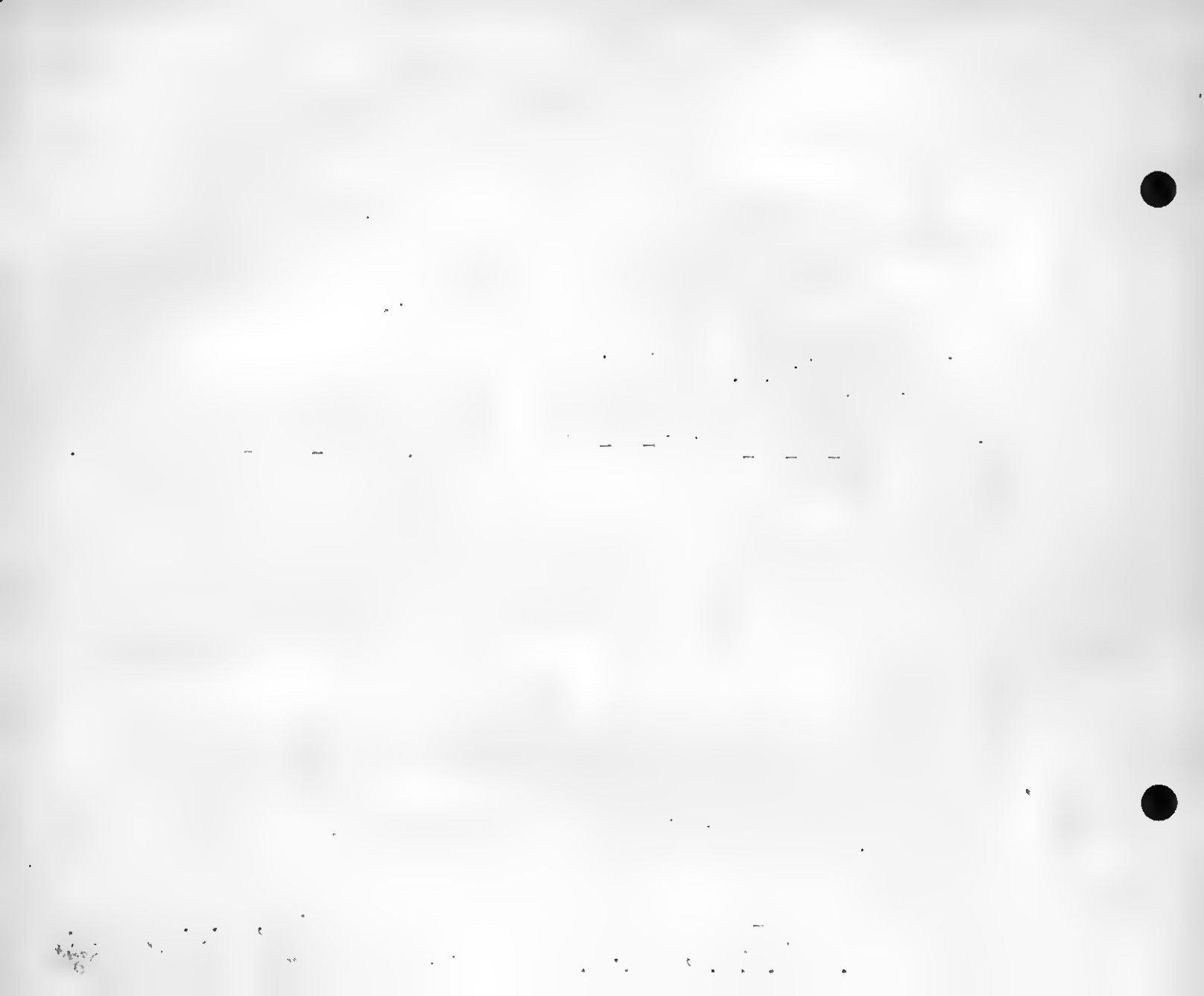
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

<div>Items 18&21 Film G378</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>05567 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05564</div>										
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>			c. LENGTH OF STAY in 1b <u>20 hrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>			d. STREET ADDRESS <u>7120 SYCAMORE</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San Hosp.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Richard Julius Kindt</u>		First Middle Last		4. DATE OF DEATH <u>Apr. 20 1966</u>		Date Month Year				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-14-93</u>		9. AGE (In years last birthday) <u>73</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>IRON Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Edward</u>					14. MOTHER'S MAIDEN NAME <u>Anna Fredricson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute suppurative meningitis; accompanied by</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>bronchopneumonia; and malignant lymphoma</u> DUE TO (c) <u>(Hodgkins Disease)</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>Belden R. Reap</u>					22. DATE SIGNED <u>April 20, 1966</u>					
EXAMINER'S NAME (Type) <u>BELDEN R. REAP</u>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>April 23, 66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>		23d. LOCATION (City, town or county) (State) <u>Prince George's County, Md.</u>	
24. FUNERAL DIRECTOR <u>W. A. Hurdemann & Son</u>					ADDRESS <u>5752 Georgia Ave N.W.</u>		25a. REC'D BY REGISTRAR <u>APR 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4
ISM 7-61

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
05566									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN b. <u>2 mo. 20 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairland Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>4600 Bowlen Road, S. E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Vera</u> Middle <u>Elizabeth</u> Last <u>Klomprens</u>					4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>19 66</u>				
5. SEX <u>Female</u>					6. COLOR OR RACE <u>White</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>Aug. 10, 1891</u>				
9. AGE (in years last birthday) <u>74</u> yrs.					10. IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u> Hours <u>12</u> Min.				
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					12. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>				
13. FATHER'S NAME <u>Charles Abell</u>					14. BIRTHPLACE (County & State, or foreign country) <u>South Haven, Mich.</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>212-24-3884</u>				
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized arteriosclerosis</u> (c) <u>Generalized arteriosclerosis</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>					18. MOTHER'S MAIDEN NAME <u>Cora Webb</u>				
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>					20. SOCIAL SECURITY NO. <u>212-24-3884</u>				
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized arteriosclerosis</u> (c) <u>Generalized arteriosclerosis</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>					22. MOTHER'S MAIDEN NAME <u>Cora Webb</u>				
23. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
25. TIME OF INJURY Month, Day, Year Hour <u>9</u> a.m. <u>21</u> p.m. <u>64</u>					26. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				
27. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					28. (City or town) <u>Silver Spring</u> (County) <u>Montgomery</u> (State) <u>Md.</u>				
29. I certify that (I) (this hospital) attended the deceased from <u>9/21/64</u> to <u>4/25/66</u> , that (I) (we) last saw the deceased alive on <u>4/25/66</u> , and that death occurred at <u>12 noon</u> from the causes and on the date stated above.					30. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
31. SIGNATURE <u>A. D. Bonifant</u>					32. DATE SIGNED <u>4/25/66</u>				
33. PHYSICIAN'S NAME (Type) <u>A. D. Bonifant, M.D.</u>					34. ADDRESS <u>Medical Center, Sandy Spring, Md.</u>				
35. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					36. DATE THEREOF <u>28 April 1966</u>				
37. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>					38. LOCATION (City, town or county) <u>Arlington, Virginia</u> (State) <u>Virginia</u>				
39. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>					40. ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>				
41. REC'D BY REGISTRAR <u>APR 29 1966</u>					42. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

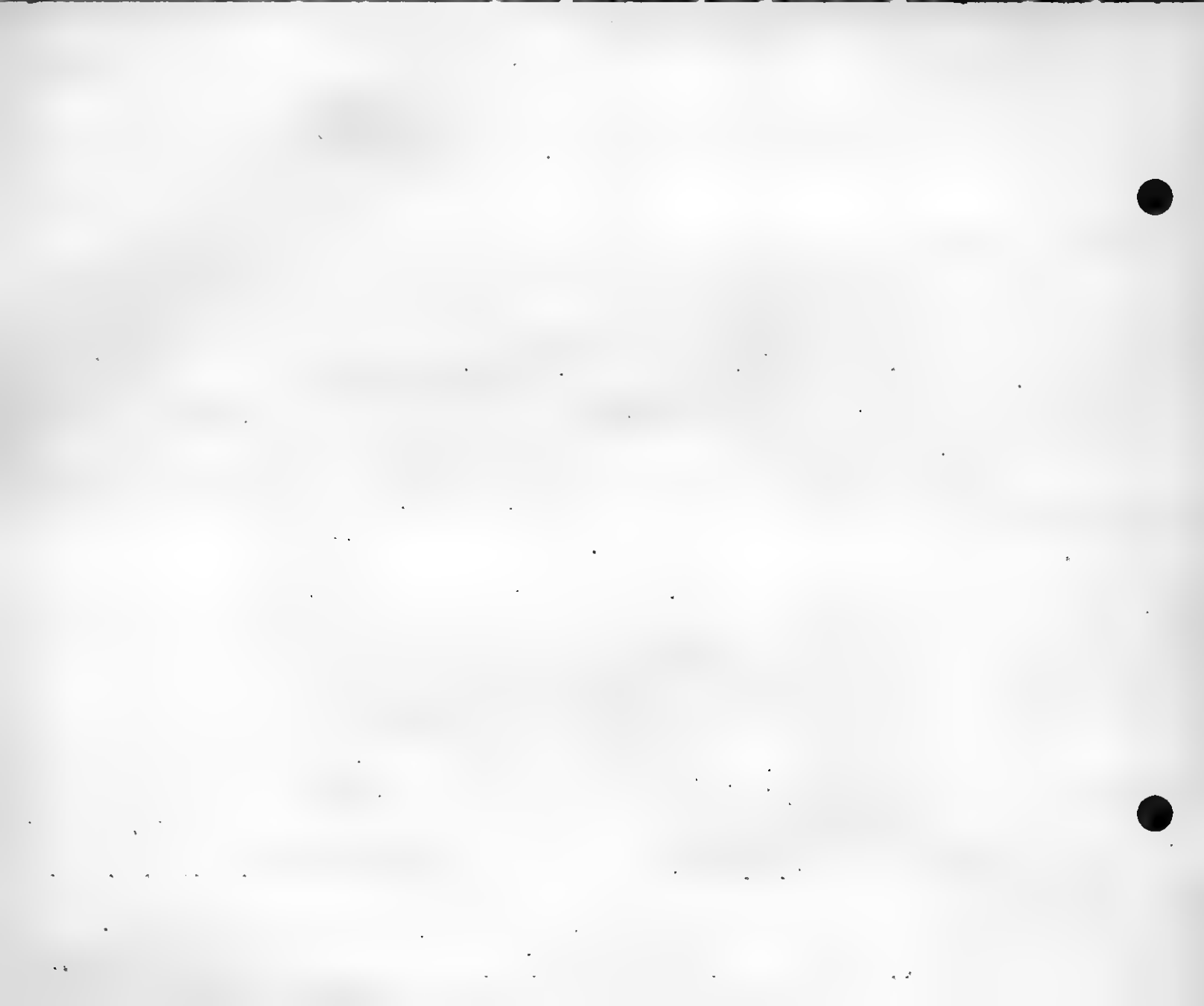


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>													
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>3 1/2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San & Hosp.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>6904-21st. Av</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <u>ROGER ENTWISTLE-LAHAYNE</u>			4. DATE OF DEATH Month <u>4</u> Day <u>26</u> Year <u>1966</u>		5. SEX <u>MALE</u>			6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>10-25-81</u>			9. AGE (In years last birthday) <u>84 yrs.</u>			10. IF UNDER 1 YEAR Months <u>4</u> Days <u>26</u> Hours <u>0</u> Min. <u>0</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Charles LAHAYNE</u>			14. MOTHER'S MAIDEN NAME <u>Virginia CLARKE</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>			16. SOCIAL SECURITY NO. <u>220-44-589</u>			17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> (b) <u>Mesenteric artery thrombosis</u> (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>4/23</u> , 19 <u>66</u> , to <u>4/26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>April 26</u> , 19 <u>66</u> , and that death occurred at <u>3:55</u> P.M., from the causes and on the date stated above.													
22a. SIGNATURE <u>W. W. Eastman</u>						22b. DATE SIGNED <u>April 26 '66</u>		22c. PHYSICIAN'S NAME (Type) <u>W. W. Eastman</u>					
22d. ADDRESS <u>831 University Blvd., E., S. S., Md.</u>						22e. M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>29 April 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Co., Md.</u>					
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>						24a. ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 05570 MARYLAND STATE DEPARTMENT OF HEALTH 05568 </div> <div style="text-align: center;"> DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>126 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Elizabeth's</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>5425 Alta Vista Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																				
3. NAME OF DECEASED (Type or print) <u>MARIE LASKY</u>			4. DATE OF DEATH Month <u>4</u> Day <u>15</u> Year <u>1966</u>		5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>															
8. DATE OF BIRTH <u>12/2/1888</u>			9. AGE (In years last birthday) <u>77</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.					10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.																							
Months	Days	Hours	Min.																						
13. FATHER'S NAME <u>Therese Lasky</u>					14. MOTHER'S MAIDEN NAME <u>Therese Lasky</u>																				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>111-111-1111</u>		17. INFORMANT <u>Marie Lasky</u>			Address <u>5425 Alta Vista Road</u>																	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT (STROKE)</u> DUE TO (b) <u>THROMBOSIS OF BASILAR ARTERY</u> DUE TO (c) <u>CEREBRAL ATHEROSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u>None</u>										INTERVAL BETWEEN ONSET AND DEATH <u>24-30 HRS</u> <u>24-30 HRS</u> <u>UNKNOWN</u>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)																						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)																		
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 22, 1965</u> , to <u>APRIL 15, 1966</u> , that (I) (we) last saw the deceased alive on <u>APRIL 15, 1966</u> , and that death occurred at <u>3:00 P.M.</u> , from the causes and on the date stated above.																									
22a. SIGNATURE <u>Edward A. Beeman</u>					22b. DATE SIGNED <u>4/15/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Edward A. Beeman, M.D.</u>		22d. ADDRESS <u>1015 Spring St., Silver Spring, Md.</u>																
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>APRIL 17, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BETH ISRAEL CEMETERY</u>			23d. LOCATION (City, town or county) (State) <u>WOODBIDGE</u> <u>N.Y.</u>																	
24. FUNERAL DIRECTOR <u>B. D. Dargatzis & Sons</u>					25a. REC'D BY REGISTRAR <u>APR 22 1966</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>																		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <u>MARYLAND</u> b. COUNTY <u>1</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney - Box 166</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital of Silver Spring</u>						d. STREET ADDRESS <u>3411 Olney-Laytonsville Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Todd Christopher LAUGHLIN</u>						4. DATE OF DEATH Month Day Year <u>4 20 1966</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-19-66</u>		9. AGE (In years last birthday) yrs. Months Days <u>37 46</u>		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>State of Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>LAWRENCE L. LAUGHLIN</u>						14. MOTHER'S MAIDEN NAME <u>ELAINE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT (Father) <u>MR. LAWRENCE LAUGHLIN-3411 Laytonsville Rd</u>			Address <u>Olney, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neonatal asphyxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Cerebral Anoxia - Ant & post partum</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH <u>26 hrs.</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4-19-66</u> , 19 <u>66</u> , to <u>4-20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4-19</u> , 19 <u>66</u> , and that death occurred at <u>5:15</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Raymond Gibbons</u>						22b. DATE SIGNED <u>4-20-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>DR. RAYMOND GIBBONS</u>						22d. ADDRESS <u>1403 Waynewood Blvd. Alexandria Va</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>4-22-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEM.</u>		23d. LOCATION (City, town or county) (State) <u>WASHINGTON, D.C.</u>			
24. FUNERAL DIRECTOR <u>William M. Hyson</u>						Address <u>Wash, D.C.</u>		25a. REC'D BY REGISTRAR <u>APR 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05572

05570

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anthea Woodland Nursing Home 1000 Daleview Dr.</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>477</u> d. STREET ADDRESS <u>215 4th St. S.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Vera</u> Last <u>Lee</u>		4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1966</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 12, 1874</u>		9. AGE (In years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Veteran's Admin.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Milton T. Slater</u>				14. MOTHER'S MAIDEN NAME <u>Anna Patterson</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-454560</u>				17. INFORMANT <u>Robert E. Lee Jr.</u> Address <u>215-454560</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> DUE TO (b) <u>Bronchopneumonia</u> DUE TO (c) <u>4 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>May 3, 1963</u> to <u>April 13, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 12, 1966</u> , and that death occurred at <u>2:50 PM</u> , from the causes and on the date stated above.																			
22a. SIGNATURE <u>Eugene Cole</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>4.13.66</u>											
22c. PHYSICIAN'S NAME (Type) <u>Eugene Cole M.D.</u>				22d. ADDRESS <u>639 East Capitol St. Wash. D.C.</u>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>4-16-66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>				23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>							
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>				ADDRESS <u>300-4 St N.E.</u>				25a. REC'D BY REGISTRAR <u>APR 18 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05573						05571					
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				c. LENGTH OF STAY IN 1b <i>19 years</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>9708 Sutherland Road</i>						d. STREET ADDRESS <i>9708 Sutherland Road</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Jennie Charlotte Leek</i>			First Middle Last			4. DATE OF DEATH <i>April 24 1966</i>			Month Day Year		
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sep 6, 1869</i>		9. AGE (in years last birthday) <i>96 yrs.</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Michigan</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>Cornelius Struble</i>						14. MOTHER'S MAIDEN NAME <i>Agnes L. Stanton</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No None</i>				16. SOCIAL SECURITY NO. <i>YES</i>		17. INFORMANT <i>Agnes L. Brackett</i>		Address <i>6401 Hickerman Lane Rockville, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Generalized arteriosclerosis</i> <i>4500</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO (c) <i>—</i>										INTERVAL BETWEEN ONSET AND DEATH <i>Several years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>1954</i> , 19 <i>19</i> , to <i>April 24, 1966</i> , that (I) (we) last saw the deceased alive on <i>April 24, 1966</i> , and that death occurred at <i>12 PM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Bennet A. Porter, Jr.</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>April 25, 1966</i>			
22c. PHYSICIAN'S NAME (Type) <i>Bennet A. Porter, Jr., M.D.</i>						22d. ADDRESS <i>9301 Colesville Rd., Silver Spring, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2 May 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>San Gabriel Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>San Gabriel, Calif.</i>					
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>				ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>		25a. WITNESSED BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
DATE <i>APR 27 1966</i>											

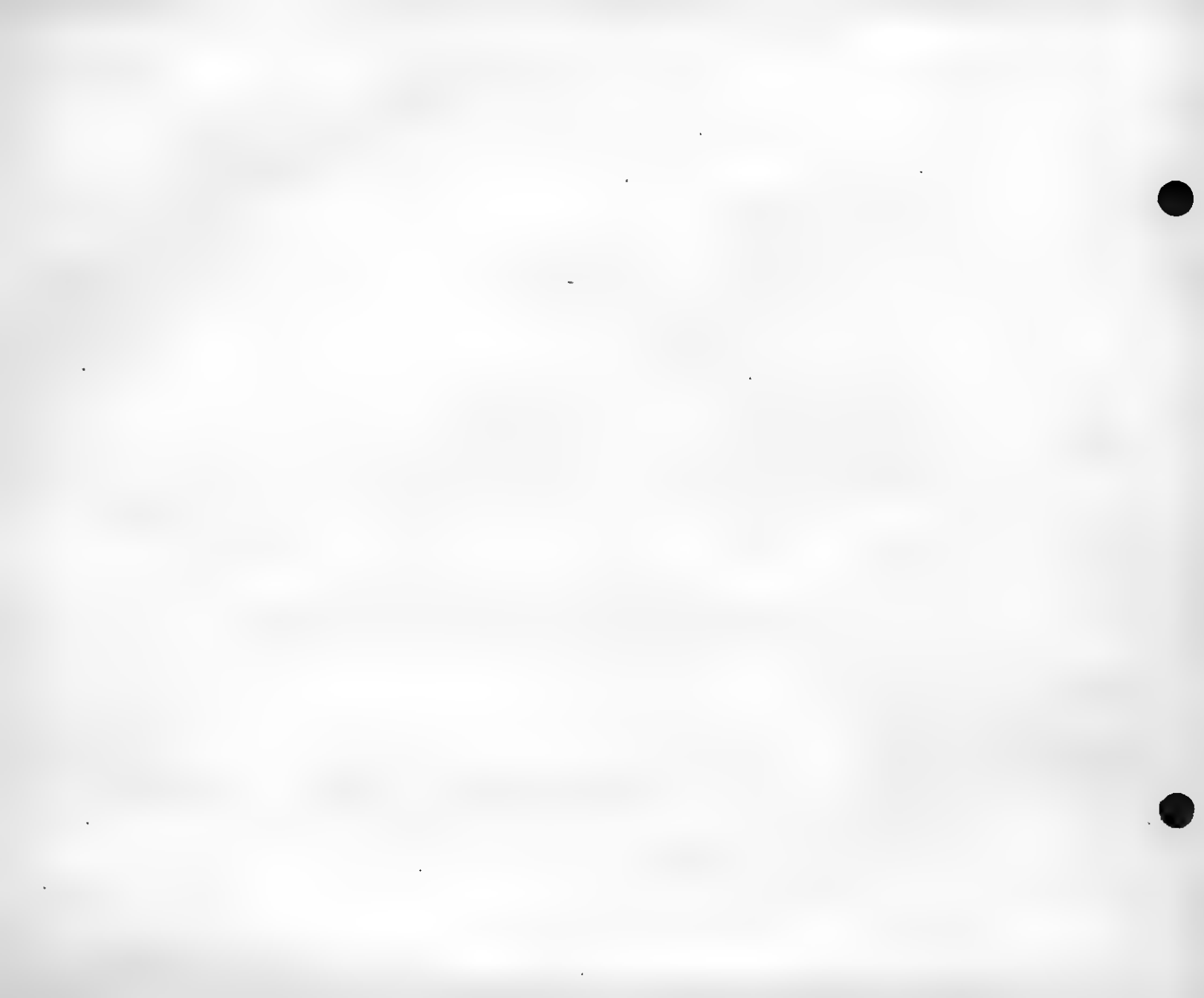
CERTIFICATE OF DEATH

05572

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>4012 Thornapple St.</u>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>LEFEVRE</u> Middle <u>LEFEVRE</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-15-1890</u>
9. AGE (In years, month, day) <u>75</u> yrs		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>19</u> Hrs <u>66</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Local Director - Nat. Industries of Blind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DR. EDWIN LEFEVRE</u>		14. MOTHER'S MAIDEN NAME <u>ESTELLA KIPPLINGER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>105-26-4075</u>	
17. INFORMANT <u>SON-IN-LAW</u> <u>J.L. BATCHELOR</u>		Address <u>203 W. MASON AVE ALEXANDRIA, VA.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> DUE TO <u>271</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Chronic Pulmonary Emphysema</u> DUE TO (c) <u>5 yr.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 1949</u> to <u>April 10 1966</u> that (I) (we) last saw the deceased alive on <u>March 4 1966</u> and that death occurred at <u>9 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Wm Fleet Luckett</u> M.D.		22b. DATE SIGNED <u>4-10-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm FLEET LUCKETT</u>		22d. ADDRESS <u>5200 Reno Pl N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-12-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>IVY HILL CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>ALEXANDRIA, VIRGINIA</u>
24. FUNERAL DIRECTOR <u>JOS. GAWLER'S SONS, INC</u>		25a. REC'D BY REGISTRAR <u>APR 14 1966</u>	
Address <u>5130 Wise Ave. N.W. WASH. D.C. 20016</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

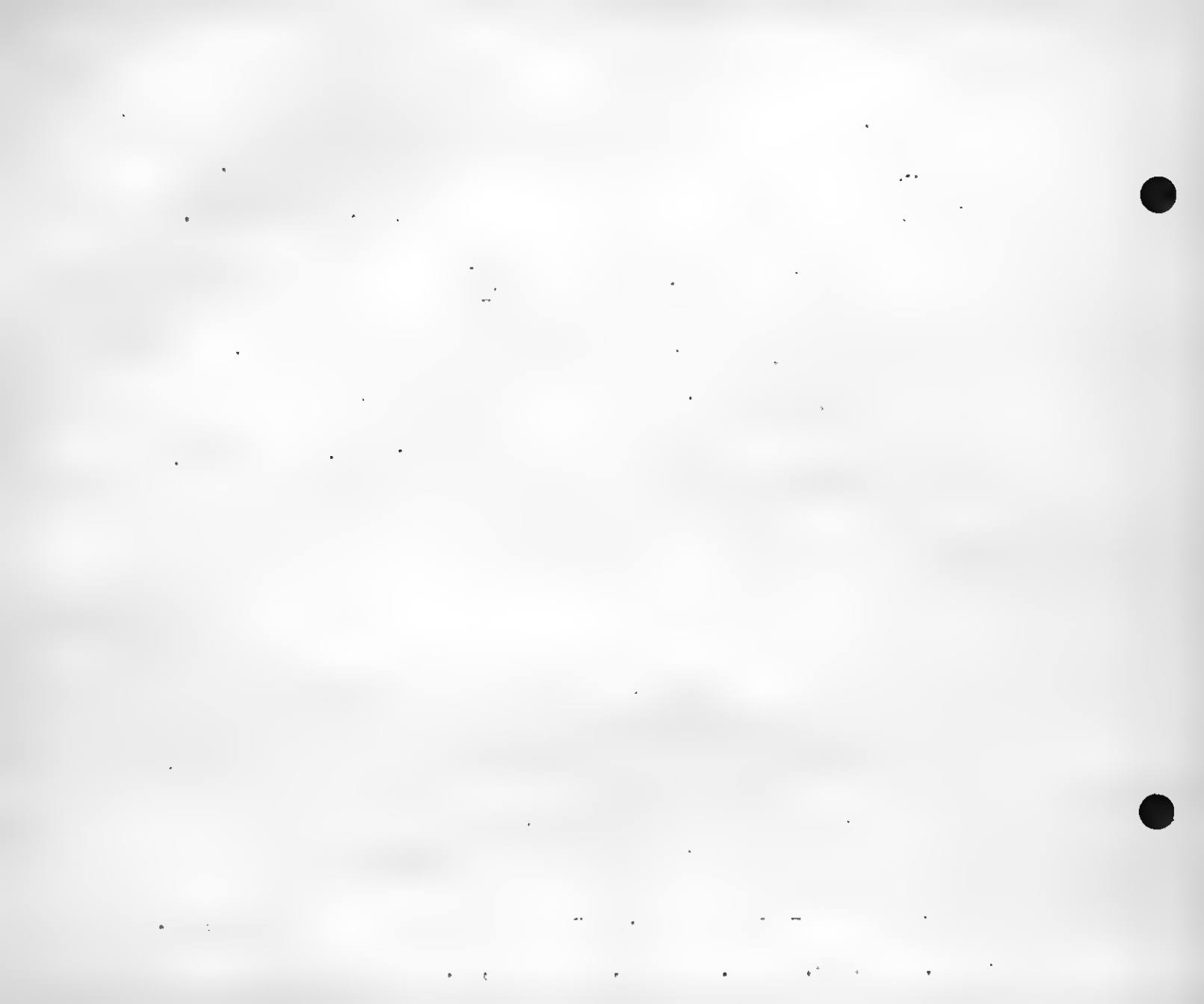
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute one certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-21 Film G377 6376 77											
MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
05573											
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney						c. LENGTH OF STAY IN 1b MONTGOMERY					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mongtomery General						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro, Rt. 2					
f. STREET ADDRESS Olney, Maryland						g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Merle Louis Lescalleet						4. DATE OF DEATH Month Day Year 4 4 1966					
5. SEX Male		6. COLOR OR RACE Whitie		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-17-22		9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heavy Equipment Opr.				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Emmitsburg, Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carl L. Lescalleet						14. MOTHER'S MAIDEN NAME Maggie Farver					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes give war or dates of service) X				16. SOCIAL SECURITY NO. 220-16-2015		17. INFORMANT Family & Medical records, Olney					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple fractures of skull and chest DUE TO (b) with exsanguination. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Deceased working operating bulldozer when a tree fell on him. 20c. TIME OF INJURY Month, Day, Year 1:35 p.m. 4/4/ 19 66 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Construction site 20f. (City or town) (County) (State) Norbeck Montg. Md.											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED April 4, 1966											
ACTUAL SIGNATURE Belden R. Reap				EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.							
23a. BURIAL, CREMATION REMOVAL (Specify) Burial				23b. DATE THEREOF 4-7-66		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery				23d. LOCATION (City, town or county) (State) Boonsboro, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.						25a. REC'D BY REGISTRAR APR 11 1966					
25b. REGISTRAR'S SIGNATURE Charles Judge											



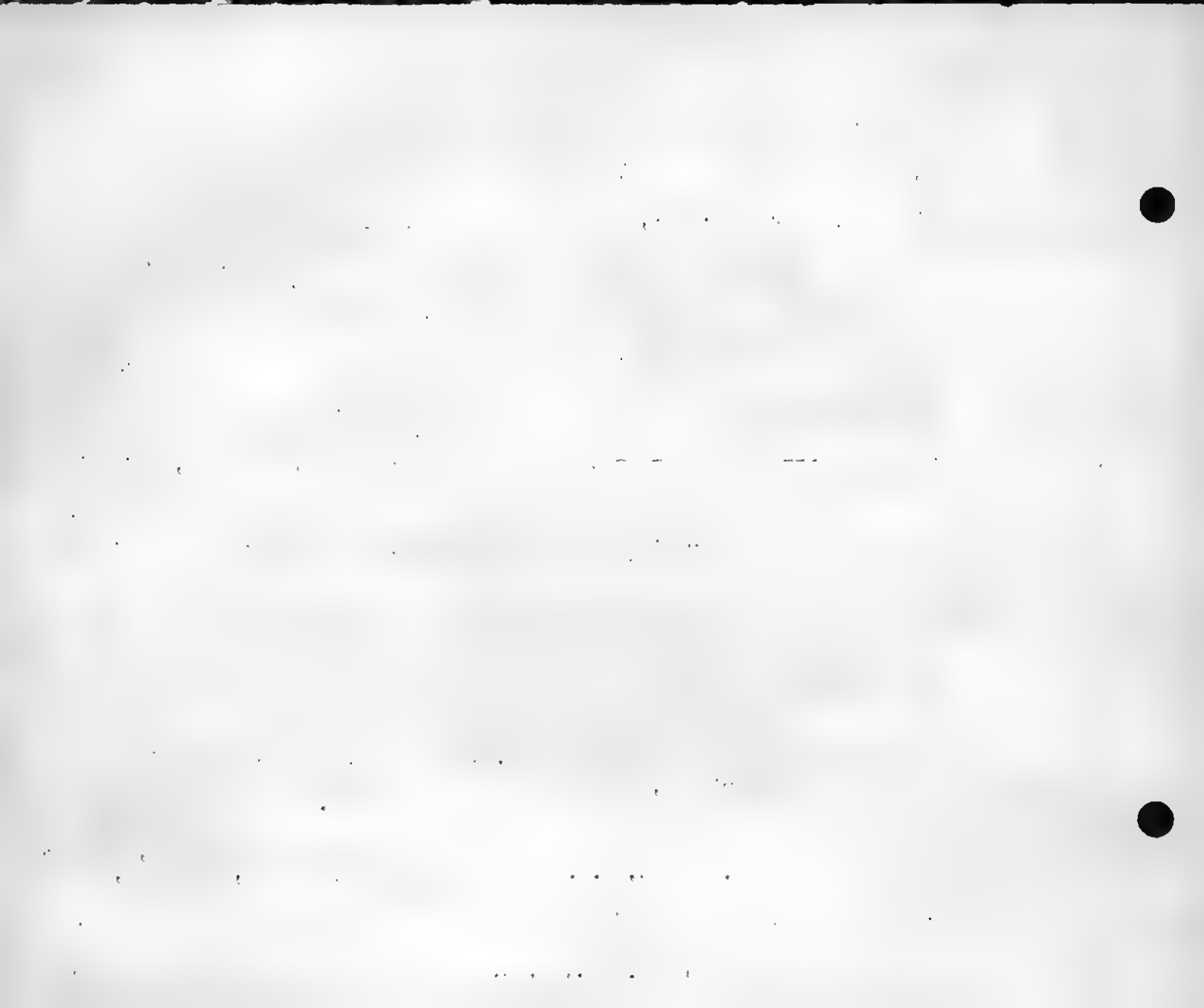
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

Item 14 Film 35

0557.

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~remove~~ employ carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

M

05577

05575

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>WASHINGTON, D. C.</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u>		c. LENGTH OF STAY IN lb <u>25 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>4340 Ellicott Street N. W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fernando</u> (n) Middle <u>Levy</u> Last <u>Levy</u>				4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 May 1924</u>		9. AGE (in years last birthday) <u>41</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brazilian Air Force</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Brazil</u>		12. CITIZEN OF WHAT COUNTRY? <u>Brazil</u>	
13. FATHER'S NAME <u>Huberto Levy</u>				14. MOTHER'S MAIDEN NAME <u>Johanna Graziella Am Ende</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO <u>—</u>		17. INFORMANT <u>Arlette Grange Levy Washington, D. C.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Post operative bleeding</u> DUE TO (b) <u>Bleeding duodenal ulcer Esophageal varices</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>March 24</u> , 19 <u>66</u> , to <u>April 17</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>April 17</u> , 19 <u>66</u> , and that death occurred at <u>0630 M</u> from causes and on the date stated above							
22a. SIGNATURE <u>C. M. Herman</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>17 April 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. M. Herman LCDR MC USN</u>				22d. ADDRESS <u>U. S. Naval Hospital Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>4-20-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sao Joao Batista Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rio de Janeiro, Brazil</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler & Sons Washington, D. C.</u>				25a. REC'D BY REGISTRAR <u>APR 19 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05576

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if not at an institution) before admission a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10505 Montrose Ave.</u>		d. STREET ADDRESS <u>10505 Montrose Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Lloyd George Lindo</u>		4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1966</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 16, 1922</u>
9. AGE (in years last birthday) <u>44</u> yrs		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>14</u> Hours <u>19</u> Mins <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Apartment</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edgar B. Lindo</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Overton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>MARGARET LINDO - 2102 - Md. Ave NE.</u>	
17. INFORMANT <u>MARGARET LINDO - 2102 - Md. Ave NE.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per Part I. Death was caused by IMMEDIATE CAUSE (a) <u>Corrigestive Heart Failure -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Hypertensive Cardio Vascular Disease.</u> DUE TO (b) <u>years</u> DUE TO (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Bell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4/14/66</u>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/19/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington, Virginia</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Stewart</u>		25a. REC'D BY REGISTRAR <u>APR 19 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If city delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

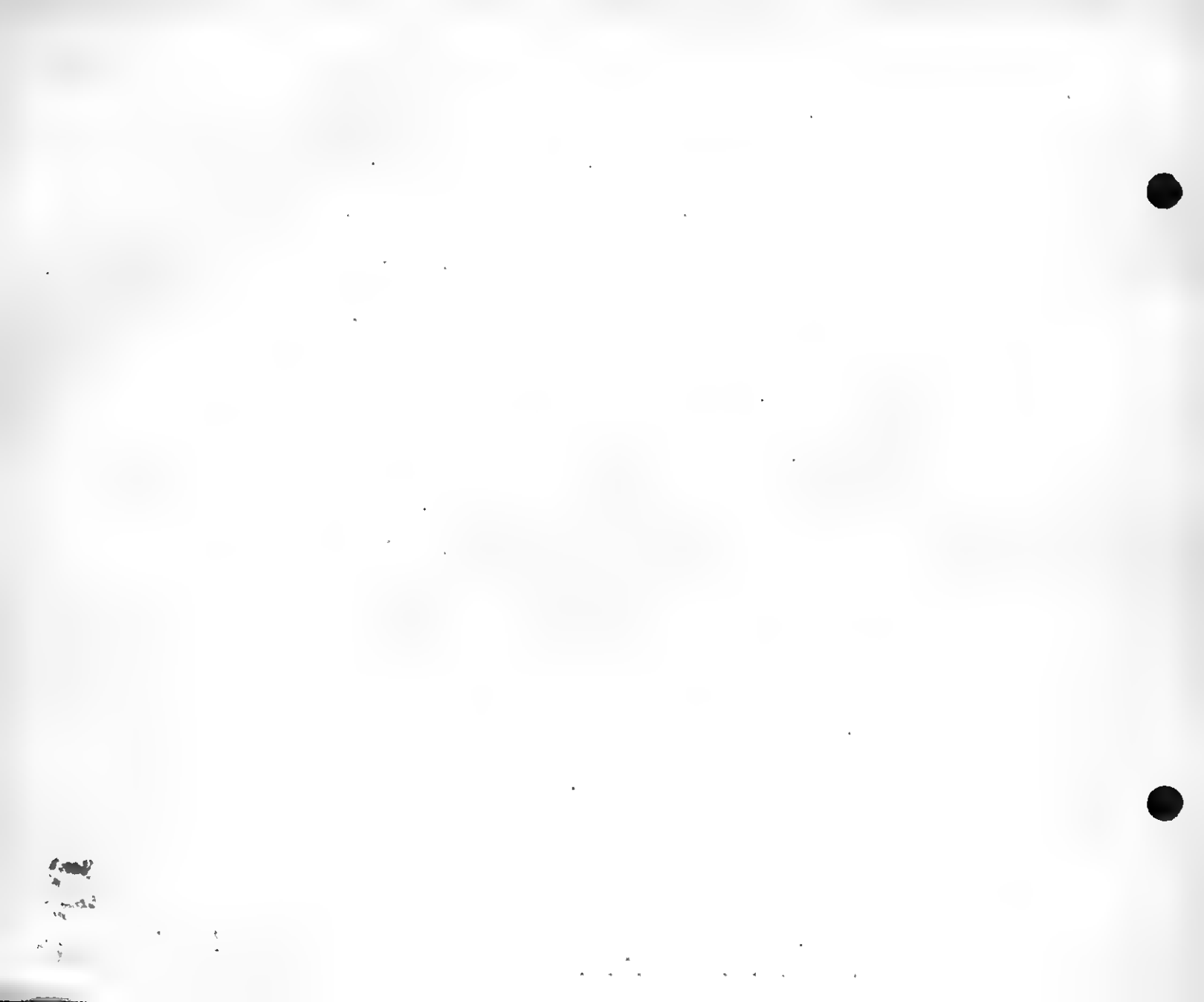
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05579

05579

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>9 Mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>N Leaton Nursing Home</u>				d. STREET ADDRESS <u>5425 Conn. Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Gruver</u> Last <u>Little</u>				4 DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1966</u>			
5 SEX <u>Fe.</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov. 26, 1876</u>	9 AGE (In years last birthday) <u>89</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob I. Gruver</u>				14. MOTHER'S MAIDEN NAME <u>Anna Weirich</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT Address <u>William Irvin - 5516-39th St. N.W.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial - Pneumonia -</u> DUE TO (b) <u>Fracture of Rt Hip -</u> DUE TO (c) <u>Cardio Vascular Disease -</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>13 Days</u> <u>Years</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fall out of chair - at nursing home fracturing Hip</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>11</u> p.m. <u>4/7</u> 19 <u>66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>		20f. (City or town) (County) (State) <u>Wheaton Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4/20/66</u>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-23-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisconsin Ave. N.W. Wash. D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



CERTIFICATE OF DEATH

05580

05578

1 PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 47 days		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital						d. STREET ADDRESS 4700 Davidson Drive						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Martha Gore		First Martha		Middle Gore		Last LIVDAHL		4 DATE OF DEATH Month April		Day 12		Year 19 66			
5 SEX Female		6. COLOR OR RACE Cauc		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH August 24, 1905		9 AGE (In years last birthday) yrs 60		10 IF UNDER 1 YEAR Months Days Hours Min		11 UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Raleigh, North Carolina				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William Arthur Gore						14. MOTHER'S MAIDEN NAME Laura Elizabeth Whitfield									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None				16. SOCIAL SECURITY NO 217-48-8280		17. INFORMANT Address Chase, Md. Orlin L. Livdahl, 4700 Davidson Dr., Chevy/									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ovarian Carcinoma with widespread metastases 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)												INTERVA. BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Feb. 24, 19 66, to April 12, 19 66, that (I) (we) last saw the deceased alive on April 12, 19 66, and that death occurred at 830 P.M. from causes and on the date stated above															
22a. SIGNATURE J. Winker						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Apr. 14, 1966							
22c. PHYSICIAN'S NAME (Type) J. Winker M. D.						22d. ADDRESS U. S. Naval Hospital, Bethesda, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF April 18, 1966		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery				23d. LOCATION (City or Town) (County) (State) Arlington, Virginia					
24. FUNERAL DIRECTOR Green Funeral Home, Merndon, Virginia						25a. RECEIVED BY REGISTRAR DATE APR 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

05581

CERTIFICATE OF DEATH

05579

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN b. <u>10 days</u>		d. STREET ADDRESS <u>5300 Westford Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lina</u> Middle <u>Huber</u> Last <u>Long</u>		4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/24/1890</u>
9. AGE (in years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>18</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>George P. Huber</u>		14. MOTHER'S MAIDEN NAME <u>Lina P. Robbins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>578-05-6170</u>	
17. INFORMANT <u>Son - William R. Long</u>		Address <u>8606 Grimsby Court Potomac, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia, Right Lung</u> 4201 DUE TO (b) <u>Cerebral Hemorrhage & Right Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>Myocardial Infarction</u> INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> <u>7 days</u> <u>11 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Heart Disease - 6 yrs.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>MAR 28, 1966</u> to <u>APR. 10, 1966</u> , that (I) (we) last saw the deceased alive on <u>APR 10 1966</u> , and that death occurred at <u>6:00 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Leo M. Curtis</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>4-10-66</u>
22c. PHYSICIAN'S NAME (Type) <u>LEO M. CURTIS</u> MD		22d. ADDRESS <u>8218 WISCONSIN AVE., BETHESDA, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/13/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>APR 12 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
05582		05580							
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>holy cross hospital of Silver Spring</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10413 Tenbrook Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Hornidas</u> Middle <u>A.</u> Last <u>Lussier</u>			4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1966</u>						
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>9/18/95</u>		9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>loom fixer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Textile mill</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Lussier</u>					14. MOTHER'S MAIDEN NAME <u>Helen Thompson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>016-09-6862</u>		17. INFORMANT <u>Mr. Philip McBride</u>			Address <u>10413 Tenbrook Dr. Silver Spring, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure, Renal failure,</u> <u>4301</u> DUE TO <u>Coronary sclerosis, Nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO <u>arteriosclerosis, genl</u> (c) <u>arteriosclerosis, legs</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>10 wks. ?</u> <u>15 wks. ?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, legs</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Apr. 5, 1966</u> to <u>Apr. 13, 1966</u> , that (I) (we) last saw the deceased alive on <u>Apr. 13, 1966</u> , and that death occurred at <u>5:42 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Philip H. Varner</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>4/13/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>PHILIP H. VARNER</u>					22d. ADDRESS <u>10620 Ga. Ave., Wheaton, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 18, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>			23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>		
24. FUNERAL DIRECTOR <u>Arthur Waters</u>					ADDRESS <u>254 Carroll St. N.W., Washington, D.C. 20012</u>		25a. REC'D BY REGISTRAR <u>APR 18 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05583

CERTIFICATE OF DEATH

05581

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c LENGTH OF STAY IN TB <u>1 mo - 3 wks</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>FAIRLAND NURSING HOME 2101 FAIRLAND</u>				d. STREET ADDRESS <u>3608 ARVIN STREET</u>			
3. NAME OF DECEASED (Type or print) <u>FISHER</u> First <u>MADEOY</u> Middle <u>MADEOY</u> Last				4. DATE OF DEATH <u>April 25</u> 19 <u>66</u> Month Day Year			
5 SEX <u>MALE</u>		6 COLOR OR RACE <u>W</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>1877 89</u> yrs.	
9 AGE (In years last birthday) <u>89</u> yrs.		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b KIND OF BUSINESS OR INDUSTRY <u>WOOD</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Russia</u>	
13. FATHER'S NAME <u>JACOB MADEOY</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO <u>577-22-667</u>		17 INFORMANT <u>PSimpley RN</u> Address <u>2101 FAIRLAND RD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO <u>SOIX</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Decomposed intervascular</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 8, 1966</u> to <u>4/25, 1966</u> that (I) (we) last saw the deceased alive on <u>4-24-66</u> 19 <u>66</u> , and that death occurred at <u>12 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Brown Pubkin</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>4/25/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>BOB L S WABKIN MD</u>				22d. ADDRESS <u>SILVER SPRING, MD 1019 W. ...</u>			
23a. BURIAL, CREMATION, REMOVA. (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-26-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ONEV JACOB CEM</u>		23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON DC</u>	
24. FUNERAL DIRECTOR <u>Shelley Funeral Home 11217 9th St NW</u>				ADDRESS		25a. REC'D BY REGISTRAR <u>APR 27 1966</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1
FOR STATE
HEALTH DEPT.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05584

05582

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND				b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b D.O.A.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland				d. STREET ADDRESS 13811 Eastland Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James Allen MANN				4. DATE OF DEATH April 9 1966				5. SEX Male			
6. COLOR OR RACE Cauc				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9 February 1931			
9. AGE (In years last birthday) 34 yrs.				10. FUNERAL 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/> Months Days Hours Min.				11. BIRTHPLACE (State or foreign country) Windfield, Alabama			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME George D. Mann				14. MOTHER'S MAIDEN NAME Bessie Wates			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES <input checked="" type="checkbox"/> (If yes give war or dates of service) active duty				16. SOCIAL SECURITY NO. 420-38-5590				17. INFORMANT Bobbie J. Mann			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of Aortic-Aneurysm. 1010 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Trauma--from Fall DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH Sudden.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Painting side of house + fell off ladder -				20c. TIME OF INJURY Month, Day, Year 11:15 am 4/9 1966			
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home -				20f. (City or town) (County) (State) Rockville Mont. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED 4/10/66			
ACTUAL SIGNATURE John G. Ball				M.D.				23a. BURIAL, CREMATION REMOVAL (Specify) Burial			
EXAMINER'S NAME (Type) JOHN G BALL				23b. DATE THEREOF 4-13-66				23c. NAME OF CEMETERY OR CREMATORY Winfield Cemetery			
23d. LOCATION (City, town or county) (State) Winfield, Alabama				24. FUNERAL DIRECTOR W.W. Chambers & Inc. 517-11th St. SE				25a. REC'D BY REGISTRAR APR 12 1966			
25b. REGISTRAR'S SIGNATURE Charles Judge											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney, c. LENGTH OF STAY IN 1b 9 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ashton d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elsie Middle Marshall Last Marshall		4. DATE OF DEATH Month April Day 12 Year 1966	
5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 13, 1894 9. AGE (in years last birthday) 72 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Walter Davis 14. MOTHER'S MAIDEN NAME Bertie Davis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Medical Records, Address Olney, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X CAPOHEMIA DUE TO DIFFUSE ABDOMINO-PELVIC METASTASIS (b) CARCINOMA, PANCREAS. DUE TO 6mo (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from JAN , 19 66 , to APRIL 12 , 19 66 , that (I) (we) last saw the deceased alive on APR. 12 , 19 66 , and that death occurred at 11:30 AM , from the causes and on the date stated above. 22a. SIGNATURE Ronald L. Lewis 22b. DATE SIGNED 4-13-66 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) 181 23b. DATE THEREOF 4-16-66 23c. NAME OF CEMETERY OR CREMATORY Hopkins Church., 23d. LOCATION (City, town or county) (State) Highland, Md.		24. FUNERAL DIRECTOR Robert L. Snodde ADDRESS Rockville, Md. 25a. REC'D BY REGISTRAR APR 22 1966 25b. REGISTRAR'S SIGNATURE John A. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05586 CERTIFICATE OF DEATH 05584									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park md</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Langley Park, md</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>					d. STREET ADDRESS <u>8228 14th Ave Apt 101</u>				
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Martin</u> Last <u>Martin</u>					4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1966</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-12-97</u>		9. AGE (In years last birthday) <u>6.8</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Samuel Ruby</u>					14. MOTHER'S MAIDEN NAME <u>Pearl Labitsky</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer metastasis</u> 1810 DUE TO (b) <u>Cancer metastasis of bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH <u>6 mrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>March 16, 1966</u> to <u>April 17, 1966</u> that (I) (we) last saw the deceased alive on <u>4/16</u> 19 <u>66</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Arthur J. Wilets</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <u>4/17/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Arthur J. Wilets, M.D.</u>					22d. ADDRESS <u>1015 Spring St., Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>April 20, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon</u>		23d. LOCATION (City, town or county) (State) <u>Hyattsville, Maryland</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Wash., DC</u>					25a. REC'D BY REGISTRAR <u>APR 18 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

FOR STATE
HEALTH DEPT.

(M)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05585

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>DC</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>5 min</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>413 Allison St NW</u>			
3. NAME OF DECEASED (Type or print) <u>Thomas O'Neil</u> First Middle Last				4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 3 1898</u> 67 yrs	
9. AGE (In years last birthday) <u>67</u> yrs		10. KIND OF BUSINESS OR INDUSTRY <u>Plumbing & Heating Business</u>		11. BIRTHPLACE (State or foreign country) <u>Wash DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas May</u>				14. MOTHER'S MAIDEN NAME <u>Johanna Lyons</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>---</u>			
17. INFORMANT <u>Dr. Thomas O'Neil Jr.</u> Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> 4:01 DUE TO (b) <u>Cardio Vascular Disease -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>17 hr.</u> <u>Years</u>
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4/5/66</u>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-8-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL. CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON, VA.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gaudin's Inc., Inc. 5130 Wisc. Ave. NW, Wash. DC</u> ADDRESS				25a. REC'D BY REGISTRAR <u>APR 7 1966</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05588

CERTIFICATE OF DEATH

05588

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY IN 1b <i>56 days</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rackville</i> d. STREET ADDRESS <i>Jeff Lane</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Raymond J. Magza</i>			4. DATE OF DEATH Month Day Year <i>4 16 1966</i>				
5. SEX <i>M</i>	6. COLOR OR RACE <i>Cau</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>6/10/11</i>	9. AGE (In years last birthday) <i>54</i> yrs	IF UNDER 1 YEAR Months Days Hours Min. <i>16 19 66</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Real Estate Broker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self-employed</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Washington, D.C.</i>			
13. FATHER'S NAME <i>Louis Victor Magza</i>			14. MOTHER'S M maiden name <i>Louise B. Juggazi</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Yes WW II</i>		16. SOCIAL SECURITY NO. <i>- - -</i>		17. INFORMANT <i>Olga M. Magza</i> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>4201</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis, Severe</i> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <i>48h</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>2-21-</i> , 19 <i>66</i> , to <i>4-16-</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>4-16-</i> , 19 <i>66</i> , and that death occurred at <i>5:30</i> P.M. from causes and on the date stated above							
22a. SIGNATURE <i>Stephen W. DeJeter</i> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4-17-66</i>		
22c. PHYSICIAN'S NAME (Type) <i>STEPHEN W. DEJETER, M.D.</i>			22d. ADDRESS <i>6719 Wilson LA, Bethesda, MD</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>4-20-1966</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Nat'l Cem. Arlington, Va.</i>		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <i>Joseph Lawler's Sons, Inc.</i> <i>5130 Wisc. Ave. N.W. Wash. DC.</i>			25a. REC'D BY REGISTRAR <i>APR 20 1966</i>		25b. REGISTRAR'S SIGNATURE <i>John M. Juggazi</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

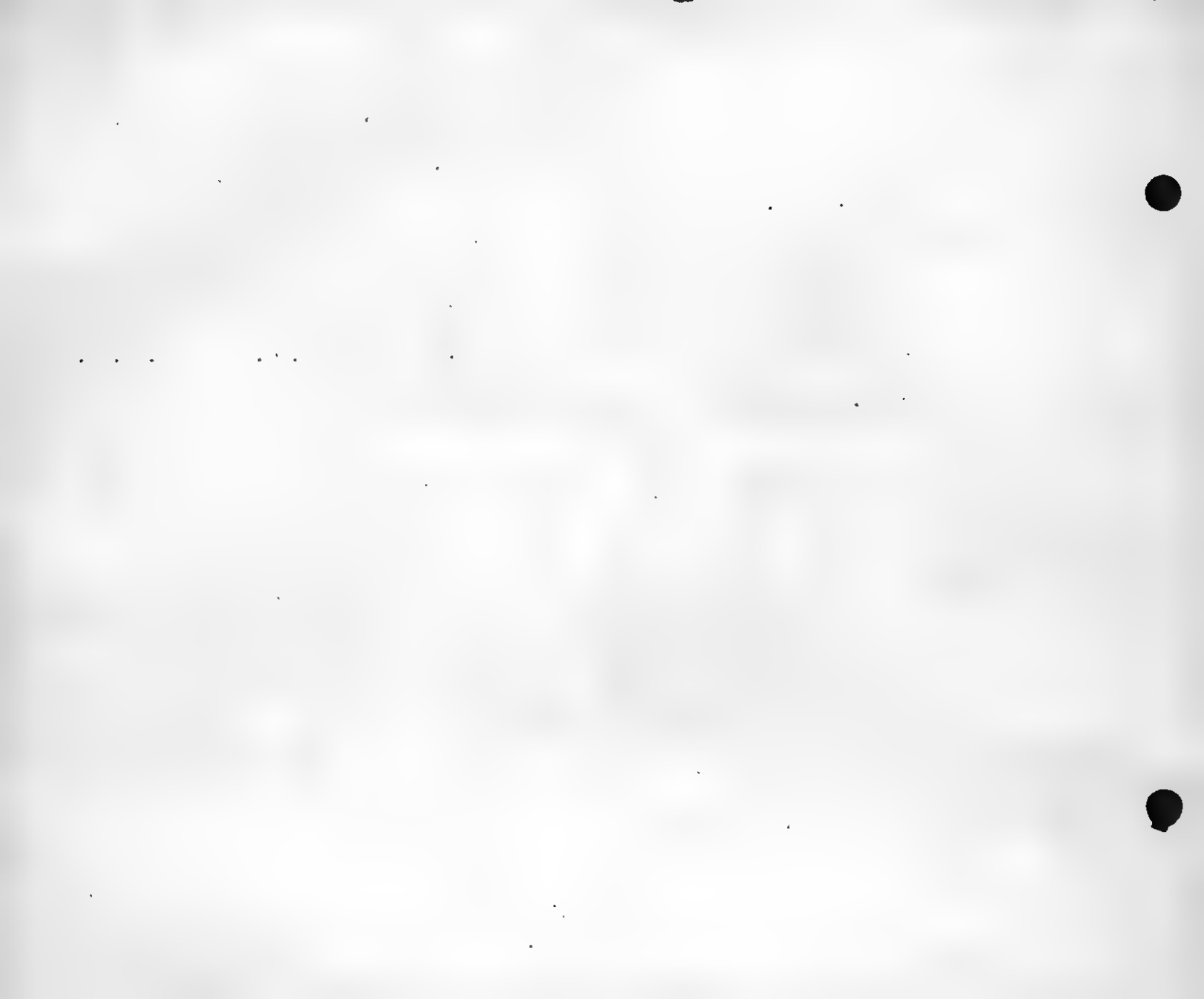
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body. Any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>4 days-</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>No. Chevy Chase</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>						d. STREET ADDRESS <u>3801 Inverness Drive</u>					
3. NAME OF DECEASED (Type or print) First <u>JANE</u> Middle <u>P.</u> Last <u>McCALLUM</u>						4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/17/1891</u>		9. AGE (In years last birthday) <u>75 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home-maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>James J. Halloran</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Savage</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. (If yes give war or dates of service) <u>214-54-7089</u>		17. INFORMANT <u>Husband -- Daniel -- Same</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> (b) <u>Obstruction</u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u> <u>4 Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>June, 1953</u> to <u>April 17, 1966</u> that (I) (we) last saw the deceased alive on <u>April 17, 1966</u> and that death occurred at <u> </u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>April 20-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>					
24. FUNERAL DIRECTOR <u>Arthur Walters</u>						25a. REC'D BY REGISTRAR <u>APR 20 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



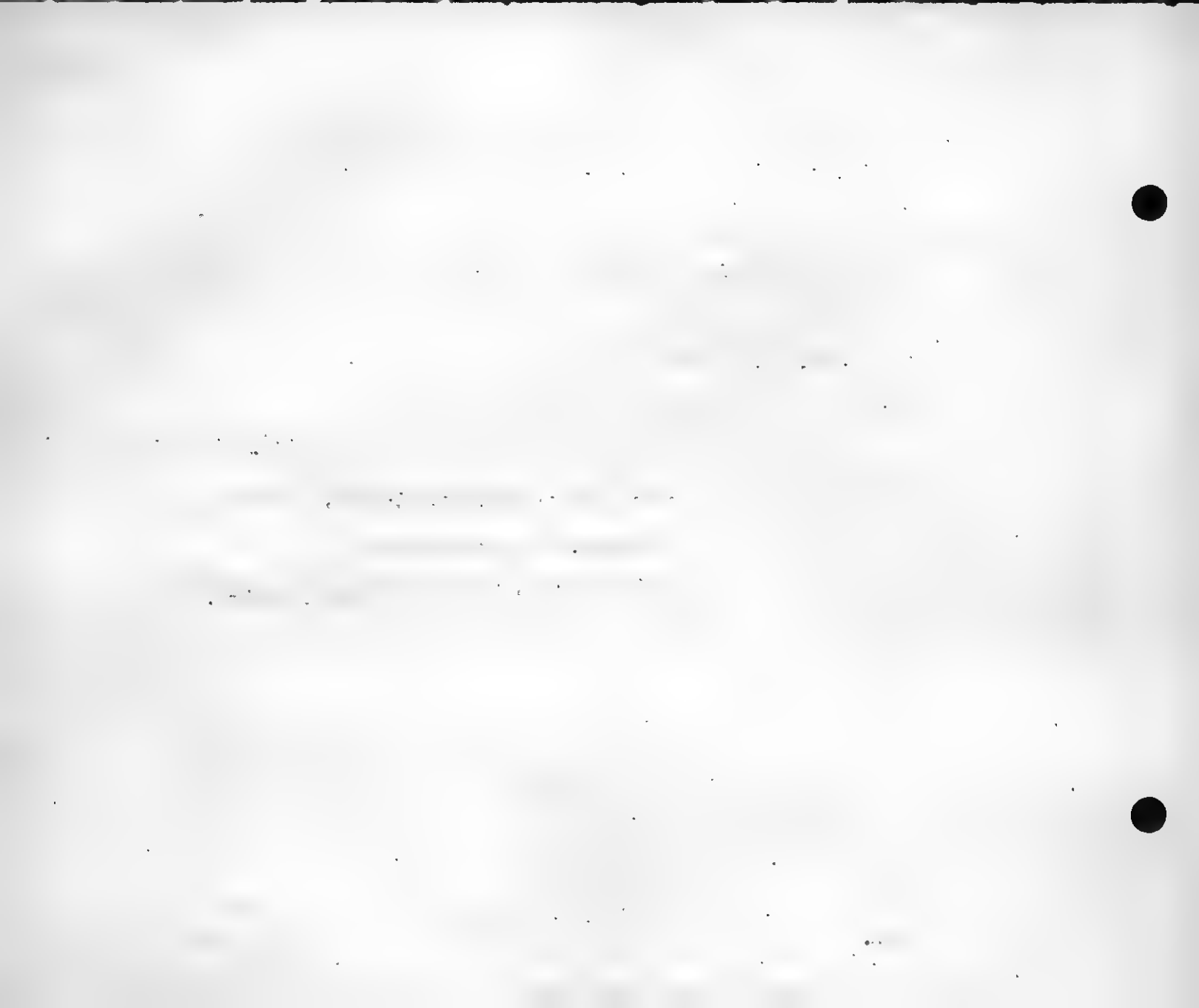
TO REMAIN ON ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1
M
Cleared to be signed by P.M.D. to sign

<div> <div>05588</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div> <div>05588</div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>D. O. A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>2025 Henderson Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Franklyn</u> Middle <u>Joseph</u> Last <u>McCarthy</u>				4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1966</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/22/14</u>		9. AGE (In years last birthday) <u>51</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>electrical Tech.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Shawmutt, Penna.</u>						12. CITIZEN OF WHAT COUNTRY? <u>US</u>					
13. FATHER'S NAME <u>Timothy Francis McCarthy</u>						14. MOTHER'S MAIDEN NAME <u>Laura Gresh</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>071-01-3769</u>		17. INFORMANT <u>Esther McCarthy</u>		Address: <u>2025 Henderson Avenue Wheaton, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease, manifest by</u> <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>1) Coronary atherosclerosis</u> DUE TO (c) <u>2) Thrombosis, anterior descending branch of left coronary.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio sclerosis</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>							
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>4/2</u> , 19 <u>65</u> , to <u>4/8</u> , 19 <u>66</u> , that (I) (two) last saw the deceased alive on <u>4/4</u> , 19 <u>66</u> , and that death occurred at <u>7:40</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>E.H. Aschenbach</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/9/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>E.H. Aschenbach</u>						22d. ADDRESS <u>1841 Col Rd. NW</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12 April 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>						25a. REC'D BY REGISTRAR <u>APR 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
05581													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>						d. STREET ADDRESS <u>8900 Sudbury Rd.</u>							
3. NAME OF DECEASED (Type or print) First <u>HANNORA</u> Middle <u>Irene</u> Last <u>MCCARTHY</u>						4. DATE OF DEATH Month <u>APRIL</u> Day <u>4</u> Year <u>1966</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 23, 1890</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Supervisor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt. Patent Off.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>John R. Brosnan</u>						14. MOTHER'S MAIDEN NAME <u>Catherine A. Roche</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-423543</u>		17. INFORMANT <u>Mrs. Irene Slattery</u> Address <u>708 Venice Drive, Silver Spring, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure (Uremia)</u> + 3 + Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Hypertensive Arteriosclerosis</u> DUE TO (c) <u>Cardiovascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>												INTERVAL BETWEEN ONSET AND DEATH <u>48 hr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) : (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>March 1966</u> to <u>April 4, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 3, 1966</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-4-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>						22d. ADDRESS <u>217 UNIV. BLVD E S.B. Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6 April 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>					
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>						ADDRESS <u>2134 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

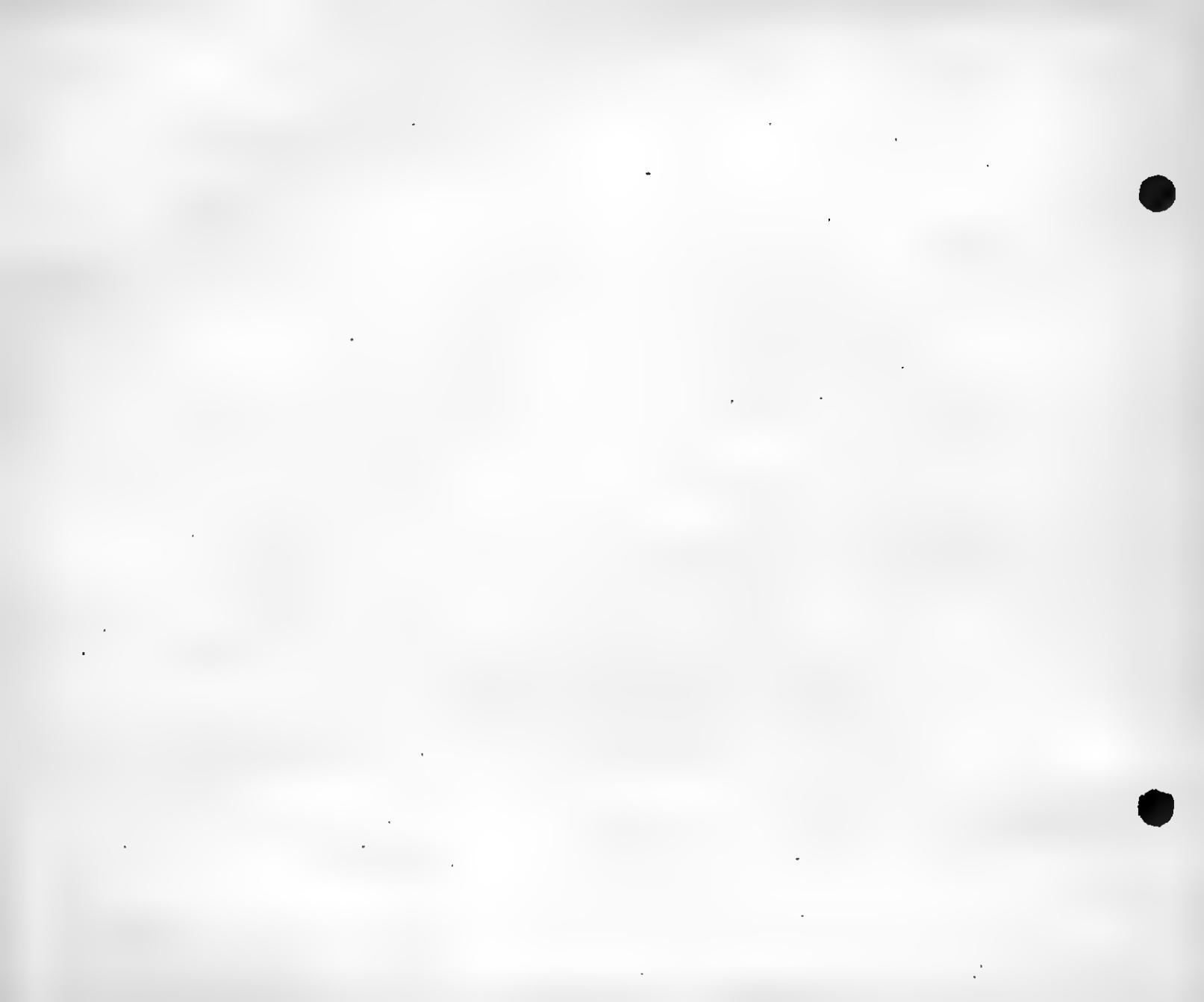
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 11823 Charen Lane					d. STREET ADDRESS Charen Lane			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle J. Last MCCARTHY		4. DATE OF DEATH Month April Day 15 Year 1966							
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1900	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months 2 Days 24 Hours Min. 		IF UNDER 24 HRS. Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Gov't		11. BIRTHPLACE (County & State, or foreign country) Michigan			12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Murthy McCarthy					14. MOTHER'S MAIDEN NAME Anna Harrington				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 577-58-1720		17. INFORMANT Son John R. McCarthy			Address Same as Item 2.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4 Arterio Sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchitis and Emphysema									INTERVAL BETWEEN ONSET AND DEATH 1 day years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 15, 1966 to April 19, 1966 , that (I) (we) last saw the deceased alive on April 15, 1966 , and that death occurred at 4:15 P.M. from the causes and on the date stated above.									
22a. SIGNATURE John J. Curry				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/16/66			
22c. PHYSICIAN'S NAME (Type) JOHN J. CURRY				22d. ADDRESS 10620 Georgia Ave. Silver Spring, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-19-66		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cem.		23d. LOCATION (City, town or county) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR APR 21 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
<div> <div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>Montgomery</div> </div> <div> <div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Takoma Park</div> </div> </div>											
<div> <div>2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)</div> <div>a. STATE</div> <div>Maryland</div> <div>b. COUNTY</div> <div>Prince George</div> </div>											
<div> <div>3. NAME OF DECEASED (Type or print)</div> <div>Jeffery Lynn McCutchan</div> </div>											
<div> <div>4. DATE OF DEATH</div> <div>4 7 1966</div> </div>											
<div> <div>5. SEX</div> <div>m</div> <div>6. COLOR OR RACE</div> <div>White</div> <div>7. MARRIED</div> <div>NEVER MARRIED</div> <div>8. DATE OF BIRTH</div> <div>11-24-55</div> <div>9. AGE (In years last birthday)</div> <div>10 yrs.</div> <div>IF UNDER 1 YEAR</div> <div>Months</div> <div>Days</div> <div>Hours</div> <div>Min.</div> </div>											
<div> <div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>School Boy</div> <div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div></div> <div>11. BIRTHPLACE (State or foreign country)</div> <div>Colorado</div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>USA</div> </div>											
<div> <div>13. FATHER'S NAME</div> <div>Morris McCutchan</div> <div>14. MOTHER'S MAIDEN NAME</div> <div>Ola Mae Merchant</div> </div>											
<div> <div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>No</div> <div>16. SOCIAL SECURITY NO.</div> <div>NONE</div> <div>17. INFORMANT</div> <div>Mrs. Morris McCutchan</div> <div>Address</div> <div>Same as 2 C-D-A</div> </div>											
<div> <div>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>Massive intraabdominal hemorrhage due to</div> <div>9105</div> <div>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</div> <div>DUE TO</div> <div>laceration of liver and right kidney.</div> <div>DUE TO</div> <div></div> <div>DUE TO</div> <div></div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> </div>											
<div> <div>19. WAS AUTOPSY PERFORMED?</div> <div>YES</div> <div>NO</div> </div>											
<div> <div>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH</div> <div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div> <div>Deceased digging a cave into sandy embankment which collapsed and crushed him.</div> <div>20c. TIME OF INJURY Month, Day, Year</div> <div>9:00 a.m. 4/7/ 66</div> <div>20d. INJURY OCCURRED</div> <div>While at work</div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>Street</div> <div>20f. (City or town)</div> <div>Hyattsville</div> <div>(County)</div> <div>Pr. Geo. Md.</div> </div>											
<div> <div>21. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from:</div> <div>Natural causes</div> <div>Accident</div> <div>Suicide</div> <div>Homicide</div> <div>Undetermined manner</div> <div>ACTUAL SIGNATURE</div> <div>Belden R. Reap</div> <div>M.D.</div> <div>CHIEF MEDICAL EXAMINER</div> <div>ASSISTANT MEDICAL EXAMINER</div> <div>DEPUTY MEDICAL EXAMINER</div> <div>22. DATE SIGNED</div> <div>April 7, 1966</div> </div>											
<div> <div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>BURIAL</div> <div>23b. DATE THEREOF</div> <div>4-11-66</div> <div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>ARLINGTON NATIONAL</div> <div>23d. LOCATION (City, town or county)</div> <div>ARLINGTON</div> <div>(State)</div> <div>VA.</div> </div>											
<div> <div>24. FUNERAL DIRECTOR</div> <div>ADDRESS</div> <div>25a. DEED BY REGISTRAR</div> <div>25b. REGISTRAR'S SIGNATURE</div> </div>											
<div> <div>W.W. Chambers Co.</div> <div>RIVERDALE, MD</div> <div>APR 12 1966</div> <div>Charles Judge</div> </div>											



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05594

05592

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Stafford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda Silver Spring Nursing Home</u>		d. STREET ADDRESS <u>7711 Northdown Rd</u>	
3. NAME OF DECEASED (Type as printed) First <u>Frederick</u> Middle <u>Laurel</u> Last <u>McDaniel</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25 - 1891</u> 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MEDICINE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>DOTHAN, ALABAMA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. Wm. McDaniel</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Larnell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes 1914-1916</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mary McDaniel</u> Address <u>Bethesda, Md.</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>10 years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Brain Syndrome</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 1965, to <u>April 9, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 9, 1966</u> , and that death occurred at <u>8:30 AM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>John David Herman</u> M.D.		22b. DATE SIGNED <u>4/9/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John David Herman</u>		22d. ADDRESS <u>4801 Montgomery Lane, B.R. 14</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-13-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARL. NAT. CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON, VIRGINIA</u>
24. FUNERAL DIRECTOR <u>JOSEPH GAUER'S SONS, INC.</u> ADDRESS <u>5730 WISC. AVE. N.W. WASH. D.C. 20016</u>		25a. REC'D BY REGISTRAR <u>DA</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

05595

05595

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Washington, D. C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 51 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 753 3rd Street S. W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Patrick Vincent McNamara		4. DATE OF DEATH Month April Day 30 Year 19 66	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-4-1894
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min 71	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Senator/Michigan		10b. KIND OF BUSINESS OR INDUSTRY U.S. Senate	
11. BIRTHPLACE (County & State, or foreign country) North Weymouth, Michigan		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Patrick Vincent McNamara		14. MOTHER'S MAIDEN NAME Mary Jane Lyne	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. - -	
17. INFORMANT Mary L. McNamara Washington, D. C.		17. ADDRESS 753 3rd Street S. W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Prostate disseminated DUE TO (b) 111X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) 5-6 years		INTERVAL BETWEEN ONSET AND DEATH 5-6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 10 , 19 66 , to 30 April , 19 66 , that (I) (we) last saw the deceased alive on 30 April , 19 66 , and that death occurred at 840 PM from causes and on the date stated above.			
22a. SIGNATURE M. W. Voss		22b. DATE SIGNED 1 May 1966	
22c. PHYSICIAN'S NAME (Type) M. W. Voss CDR MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-2-1966	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet	23d. LOCATION (City or Town) (County) (State) Detroit Michigan
24. FUNERAL DIRECTOR Joseph Gawler & Sons		25a. REC'D BY REGISTRAR MAY 9 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

05596

05594

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney, Md.</u> c. LENGTH OF STAY IN 1b <u>10 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bacone Gable Foundation</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>10422 Tawcett St. Apt. 4 - Kensington Md.</u> d. STREET ADDRESS <u>15-1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>FRANCES</u> Last <u>MC NEIL</u>		4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 11 - 1878</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>88</u> yrs. 10. IF UNDER 1 YEAR Months <u>15</u> Days <u>1</u> 11. IF UNDER 24 HRS. Hours <u>4</u> Min. <u>15</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Tennessee</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christian Henry Williamson</u> 14. MOTHER'S MAIDEN NAME <u>Dorcas Walker</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>577-03-1060</u> 17. INFORMANT <u>Frances McNeil Bezdek</u> Address <u>10422 Tawcett St. - Kensington Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>47.1 X</u> DUE TO <u>Congestive heart failure with Pulmonary edema</u> (b) <u>2 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Broncho pneumonia</u> (c) <u>47 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral and generalized arteriosclerosis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>-</u> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month, Day, Year <u>July 2, 1965</u> to <u>April 28, 1966</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u> 20f. (City or town) <u>BURTONSVILLE, MD.</u> (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 2, 1965</u> to <u>April 28, 1966</u> that (I) (we) last saw the deceased alive on <u>April 26, 1966</u> and that death occurred at <u>6:45 P.M.</u> From the causes and on the date stated above.			
22a. SIGNATURE <u>John R. Spencer</u> 22b. DATE <u>4-28-66</u> 22c. PHYSICIAN'S NAME (Type) <u>JOHN R. SPENCER</u> 22d. ADDRESS <u>BURTONSVILLE, MD.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>5-2-1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> 23d. LOCATION (City, town or county) <u>Rockville, Md.</u> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawler's Sons, Inc.</u> 25a. REC'D BY REGISTRAR <u>MAY 2 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		26. ADDRESS <u>5130 Wisc. Ave. NW. Wash. DC.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05597

CERTIFICATE OF DEATH

05595

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN lb 25 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 2700 BARKER ST e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) FLORENCE C. McNichol First Middle Last		4 DATE OF DEATH April 21 1966 Month Day Year	
5 SEX FEMALE	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-26-1889 9. AGE (In years last birthday) 76 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) NEW YORK
13 FATHER'S NAME FRANCIS COLEMAN		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 126-09-1415	
17 INFORMANT JANICE McNichol HAYES - Daughter Address			
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 DUE TO Probable coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized & coronary arteriosclerosis DUE TO years (c)			INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pyelonephritis			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from March 27 1966 to April 21 1966 that (1) (we) last saw the deceased alive on April 21 1966 and that death occurred at 4:45 M, from causes and on the date stated above.			
22a. SIGNATURE G. Bowditch Hunter, Jr.		22b. DATE SIGNED April 21, 1966	
22c. PHYSICIAN'S NAME (Type) G. Bowditch Hunter, Jr.		22d. ADDRESS Tenley Building, Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/23/66	23c. NAME OF CEMETERY OR CREMATORY Ivy Hill	23d. LOCATION (City or Town) (County) (State) Alexandria, Virginia
24. FUNERAL DIRECTOR Tyson Wheeler		25a. RECD BY REGISTRAR APR 25 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>7900 Wildwood Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Donald</u> Last <u>Medvee</u>			4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1966</u>		5. SEX <u>M</u>			6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Director</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Art Dept.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Alex. Medvee</u>					14. MOTHER'S MAIDEN NAME <u>Mary Sotak</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>WW2 Army unknown</u>			16. SOCIAL SECURITY NO. <u>Record</u>		17. INFORMANT Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia + Anemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple Myeloma</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>65</u> , to <u>April 11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>April 11</u> , 19 <u>66</u> , and that death occurred at <u>4:25</u> P.M., from the causes and on the date stated above.											
22a. SIGNATURE <u>James H. Nelson</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>April 11, 1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>JAMES H. NELSON</u>					22d. ADDRESS <u>7600 CARROLL AVE TAKOMA PARK MD</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>April 14 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Georgetown Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Georgetown Md.</u>					
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>254 Carroll Ave. N.W. Washington, D.C. 20012</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>APR 13 1966</u>					

BP

05599

CERTIFICATE OF DEATH

05599

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>27 days</i>		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>						d. STREET ADDRESS <i>9204 Edgewood Drive</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Harriet C. Michalski</i>		First		Middle		Last		4. DATE OF DEATH Month <i>April</i>		Day <i>19</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-16-16</i>		9. AGE (In years last birthday) <i>50</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. SOCIAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Illinois</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Gene F. Hebard</i>						14. MOTHER'S MAIDEN NAME <i>Orpha Buenside</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes (a) or unknown) (If yes give war or dates of service) <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO. <i>340-22-2530</i>		17. INFORMANT Name <i>Charles - Husband - Same</i> Address					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CARDIOVASCULAR COLLAPSE</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>ACUTE MYELOCYTIC LEUKEMIA</i> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>6 MONTHS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>APRIL 18</i> , 19 <i>66</i> , to <i>APRIL 19</i> , 19 <i>66</i> ; that (I) (we) last saw the deceased alive on <i>APRIL 18</i> , 19 <i>66</i> , and that death occurred at <i>1:20</i> A.M., from causes and on the date stated above.											
22a. SIGNATURE <i>Robert C. Daddario</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4/19/66</i>			
22c. PHYSICIAN'S NAME (Type) <i>ROBERT C. DADDARIO M.D.</i>						22d. ADDRESS <i>5413 CEDAR LANE BETHESDA MD</i>					
23a. BURIAL, CREMAT., OR REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4/22/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>				23d. LOCATION (City or Town) (County) (State) <i>Arlington, Virginia</i>			
24. FUNERAL DIRECTOR <i>Tyner Wheeler</i>				25a. REC'D BY REGISTRAR <i>APR 20 1966</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in agreement, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		c. LENGTH OF STAY IN 1b SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) POTOMAC VALLEY NURSING HOME		d. STREET ADDRESS 2028 LANIER DRIVE	
3. NAME OF DECEASED (Type or print) First INEZ Middle BATES Last MILLER		4. DATE OF DEATH Month 4 - Day 9 Year 1966	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-30-85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY - TREASURER		10b. KIND OF BUSINESS OR INDUSTRY AIR FORCE REGISISTRAR	9. AGE (In years last birthday) 81
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES FREDERICK MILLER		14. MOTHER'S MAIDEN NAME EVELYN BATES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 578-01-3670	
17. INFORMANT MRS. MARION FARQUHAR		Address SAME AS #2 ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) arteriosclerosis - generalized DUE TO (c) diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH 4 days 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 to 4-9 , 1966, that (I) (we) last saw the deceased alive on 4-9 1966, and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE I. Hammond Mill		22b. DATE SIGNED 4-9-66	
22c. PHYSICIAN'S NAME (Type) I. HAMMOND MILL		22d. ADDRESS 3800 JENIFER ST. N.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-13-66	
23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION (City, town or county) (State) SUITLAND, MARYLAND	
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SONS, INC.		25a. REC'D BY REGISTRAR APR 12 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05601

05599

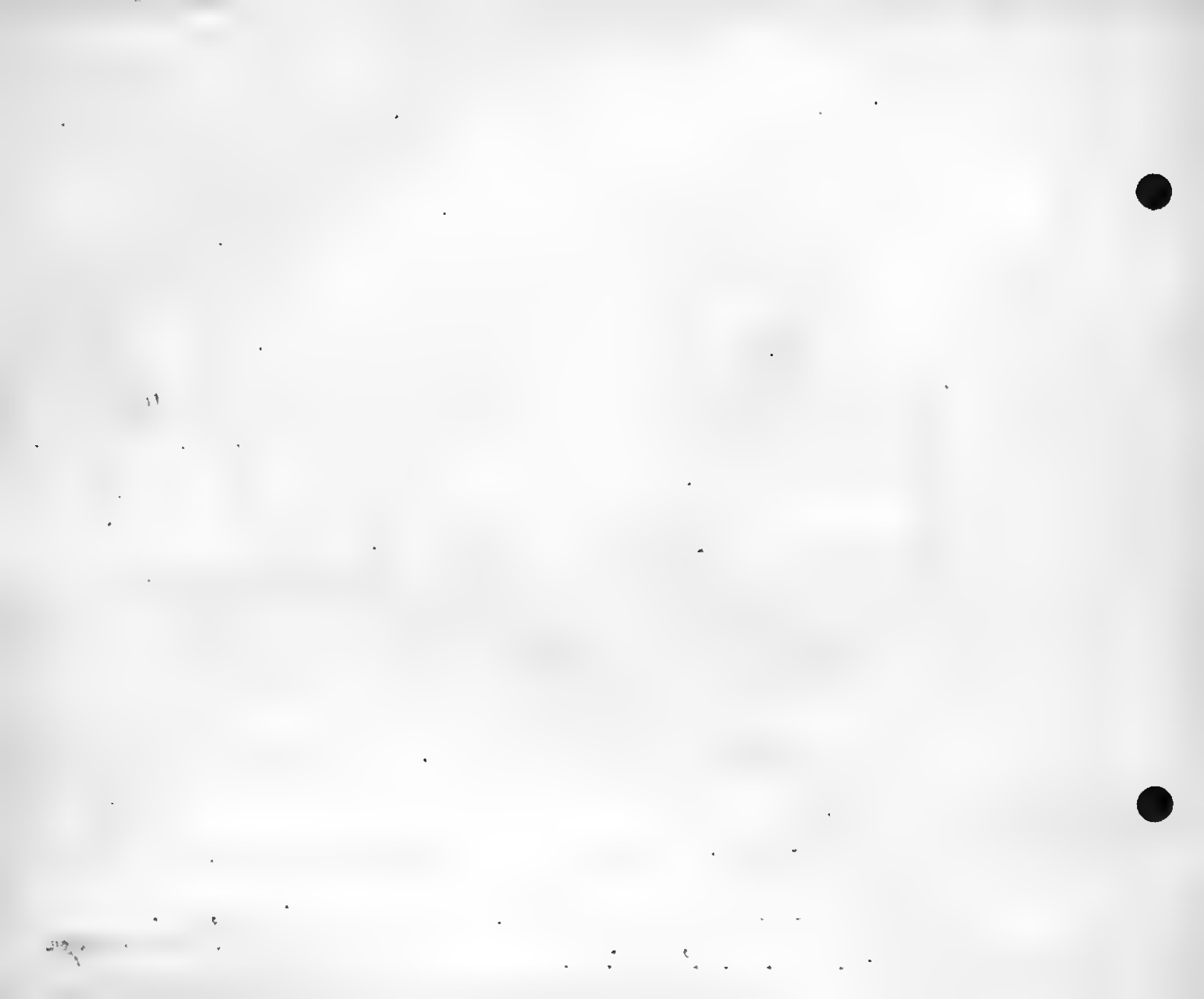
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>15 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Petersburg</u> <u>75</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>Route #1, Box 38B</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lisa</u> Middle <u>Lynn</u> Last <u>Mongold</u>				4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>19 66</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6 January 1966</u>	9. AGE (In years last birthday) yrs. <u>2</u> Months <u>28</u> Days <u>28</u> Hours <u>Min.</u>	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Mongold</u>				14. MOTHER'S MAIDEN NAME <u>Carol Sites</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Records</u> Address <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tracheal mucous plug</u> <u>3362</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Weak respiration and cough</u> DUE TO (c) <u>Infantile spinal muscular atrophy</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u> <u>since birth</u> <u>since birth</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>OK</u> (this hospital) attended the deceased from <u>19 March</u> , 19 <u>66</u> , to <u>3 April</u> , 19 <u>66</u> that <u>NO</u> (we) last saw the deceased alive on <u>3 April</u> , 19 <u>66</u> , and that death occurred at <u>9:40</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Jon D. Dorman</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>4 April 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Jon D. Dorman, M.D.</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr 6, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>North Mill Creek Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Dorcas W. Va.</u>	
24. FUNERAL DIRECTOR <u>Swift H. Brundall</u>				ADDRESS <u>Fairfax, Va.</u>		25a. REC'D BY REGISTRAR <u>APR 6 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>7 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7708-Marbury Road-</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>7708 Marbury Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LYFORD</u> Middle <u>MARSTON</u> Last <u>MOORE</u> 4. DATE OF DEATH <u>April 19</u> 19 <u>66</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan. 3, 1881</u> 9. AGE (in years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Broker</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Highland, Ohio</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Samuel Moore</u> 14. MOTHER'S MAIDEN NAME <u>Selina Woodmansee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>272-30-3465</u> 17. INFORMANT <u>George Moore - 5100 Lowell Lane Wash. D.C.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Broncho pneumonia</u> 3049 DUE TO (b) <u>General Debility</u> DUE TO (c) <u>Cerebral & generalized Arteriosclerosis</u> 7yrt CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> , 19 <u> </u> to <u>April 19, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 18, 1966</u> , and that death occurred at <u>2:30</u> AM, from the causes and on the date stated above.	
22a. SIGNATURE <u>E. Nicklas</u> 22c. PHYSICIAN'S NAME (Type) <u>EDWARD NICKLAS</u>		22b. DATE SIGNED <u>4/19/66</u> 22d. ADDRESS <u>4830 V.S.N.W. Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 23b. DATE THEREOF <u>4-23-1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> 23d. LOCATION (City, town or county) (State) <u>Suitland, Md.</u>		24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> ADDRESS <u>5130 Wisc. Ave. N.W. Wash. DC.</u> 25a. RECD BY REGISTRAR <u>APR 25 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in a vault within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05603

05601

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY IN lb <u>Years</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7139 Maple Ave.</u>		e STREET ADDRESS <u>7139 Maple Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Ivy Greene Morris</u>		4 DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1966</u>	
5 SEX <u>Fe</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov. 18, 1882</u>
9 AGE (In years last birthday) <u>83</u> yrs		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Veterans Admin. Employee Federal Govt</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Penn</u>	
11 BIRTHPLACE (State or foreign country) <u>Penn</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>John. Greene.</u>		14 MOTHER'S MAIDEN NAME <u>Ada F</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO	
17 INFORMANT <u>John F. Palmer, 6100 Edgewood Dr. Alex Va</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO (b) <u>Cardio Vascular Disease -</u> DUE TO (c) <u>Years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John E. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN E. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4/15/66</u>	
		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>April 16, 1966</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Mount Comfort Cemetery</u>		23d LOCATION (City or town) (County) (State) <u>Alexandria Virginia</u>	
24 FUNERAL DIRECTOR <u>John Walters, 254 Cornell N.W. DC</u>		25a REG'D BY REG STRAR <u>APR 18 1966</u>	
		25b REG STRAR'S SIGNATURE <u>John Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

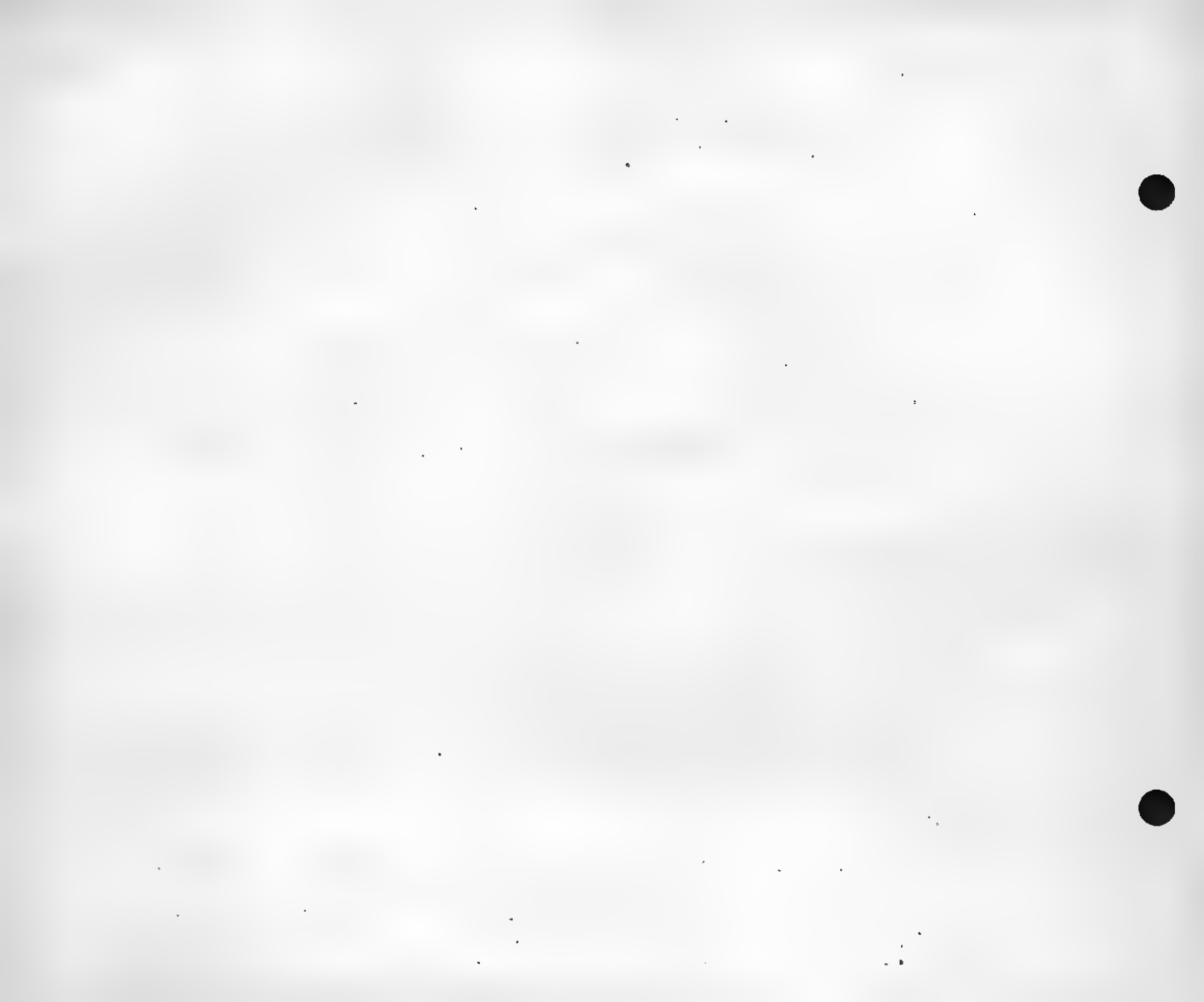
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg c. LENGTH OF STAY IN ID 1 Yr. 3 Mos. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9 Summit Drive					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg d. STREET ADDRESS 9 Summit Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) BERNICE V. MURRAY			4. DATE OF DEATH Month April Day 21 Year 1966		5. SEX Female			6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) North Carolina			12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Angus Hunter McLendon					14. MOTHER'S MAIDEN NAME Eliza Jane Harring						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Gladys Arundel Address Gaithersburg, Md						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____										INTERVAL BETWEEN ONSET AND DEATH 1 hour years	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 15, 1960</u> to <u>April 21, 1966</u>, that (I) <u>two</u> last saw the deceased alive on <u>April 6, 1966</u>, and that death occurred at <u>12:30</u> M. from the causes and on the date stated above.											
22a. SIGNATURE Stephen C. Cromwell					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-21-66				
22c. PHYSICIAN'S NAME (Type) STEPHEN C. CROMWELL, JR.					22d. ADDRESS Rockville, Maryland 615 W. Montgomery Ave.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4/23/66		23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery			23d. LOCATION (City, town or county) (State) Gaithersburg, Md.			
24. FUNERAL DIRECTOR R.A. Humphrey Address Bethesda, Md.					25a. REC'D BY REGISTRAR APR 25 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
05605					05603				
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>Silver Spring</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE, MARYLAND</u> d. STREET ADDRESS <u>13925 MARIANA DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>DONALD</u> Middle <u>William</u> Last <u>NEWBY</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>7</u> Year <u>1966</u>						
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/29/12</u>		9. AGE (in years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newby Upholstery</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>		11. BIRTHPLACE (County & State, or foreign country) <u>DAVIDSON COUNTY, NORTH CAROLINA</u>			12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>	
13. FATHER'S NAME <u>Wm H. Newby</u>					14. MOTHER'S MAIDEN NAME <u>Carrie Alma Kennedy</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>			16. SOCIAL SECURITY NO. <u>240-03-3582</u>		17. INFORMANT <u>Kathryn B. Newby</u> Address <u>13925 Mariana Dr. Rockville, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> <u>COX</u> DUE TO (b) <u>Ruptured aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u>96 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3 Apr</u> , 19 <u>66</u> , to <u>7 Apr</u> , 19 <u>66</u> , that (II) (we) last saw the deceased alive on <u>6 Apr</u> , 19 <u>66</u> , and that death occurred at <u>5:05 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Paul J. Noone</u>						22b. DATE SIGNED <u>7 Apr 66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Paul J. Noone</u>						22d. ADDRESS <u>5201 Randolph Rd., Rockville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8 April 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove Methodist Church Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Davidson Co., N. C.</u>			
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>						25a. REC'D BY REGISTRAR <u>APR 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE HEALTH DEPT.

05606

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05604

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		2 USUAL RESIDENCE (Where deceased lived if inst. l'ed on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hospital</u>		d. STREET ADDRESS <u>9606 Mc. Alpine Rd</u>	
3 NAME OF DECEASED (Type or print) <u>LEON</u> First <u>Newman</u> Middle <u></u> Last <u></u>		4. DATE OF DEATH Month <u>4</u> - Day <u>1</u> - Year <u>1966</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-5-14</u> 9. AGE (n years lost birthday) yrs <u>52</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHEMICAL ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T</u>	11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>
13. FATHER'S NAME <u>SAMUEL NEWMAN</u>		14. MOTHER'S MAIDEN NAME <u>ROSE KAFIN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-442403</u>	17. INFORMANT <u>Mrs Ruth P. Newman</u> Address <u>Same As 2</u>
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> <u>4201</u> DUE TO (b) <u>Coronary artery heart disease</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Read</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. READ M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>April 2, 1966</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-3-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NAT'L MEM. PARK</u>	23d. LOCATION (City or town) (County) (State) <u>FALLS CHURCH VA.</u>
24. FUNERAL DIRECTOR <u>Holberg Funeral Home</u>		25a. REC'D BY REGISTRAR <u>APR 5 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY <u>Wash. D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens</u>		d. STREET ADDRESS <u>2101-31 Place S.E.</u>	
3. NAME OF DECEASED (Type or print) <u>Zula V. Newton</u> First Middle Last		4. DATE OF DEATH <u>April 23 1966</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 30 1878</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. FINDER 1 YEAR <u>87</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albion T. Murphy</u>		14. MOTHER'S MAIDEN NAME <u>Alice Lee Cox</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Y.H. Margolis</u> Address <u>1244 Martha Custard St. N.W. Washington, D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Influenza</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 25, 1965</u> , to <u>April 23, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 23 1966</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>David L. Rogers</u>		22b. DATE SIGNED <u>April 23, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>David L. Rogers</u>		22d. ADDRESS <u>1712 I St. N.W., Washington, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 26, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>		23d. LOCATION (City, town or county) (State) <u>Washington, DC</u>	
24. FUNERAL DIRECTOR <u>Lee General Home</u>		25a. REC'D BY REGISTRAR <u>APR 27 1966</u>	
ADDRESS <u>Washington D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05608		05606									
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>913 Edgemoor</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>B</u> Last <u>NOFTSKER</u>		4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1966</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>9</u> Day <u>26</u> Year <u>1926</u>	
9. AGE (In years last birthday) <u>39</u> yrs.		10. UNDER 1 YEAR Months <u>1</u> Days <u>17</u> Hours <u>17</u> Min. <u>66</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>County Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City Manager</u>	
13. FATHER'S NAME <u>George W. Nofsker</u>						14. MOTHER'S MAIDEN NAME <u>Anna M. Bogelsonger</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>200-22-5464</u>		17. INFORMANT <u>Bill Seoren</u>		Address <u>913 Edgemoor Rd. Silver Spring, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia - Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Nephrosclerosis</u> (c) <u>Arteriosclerosis, generalized.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>years.</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>4/12</u> , 19 <u>66</u> , to <u>4/17</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/16</u> , 19 <u>66</u> , and that death occurred at <u>3:45 A.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>James R. Coleman MD.</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u>		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <u>9241 COLUMBIA BLVD SILVER SPRING MARYLAND</u>		22b. DATE SIGNED <u>4/17/66</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-20-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Springhill</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland County, Penn.</u>		24. FUNERAL DIRECTOR <u>Werner & Humphrey Inc.</u>		ADDRESS <u>5434 Faber</u>		25a. REC'D BY REGISTRAR <u>APR 22 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05609

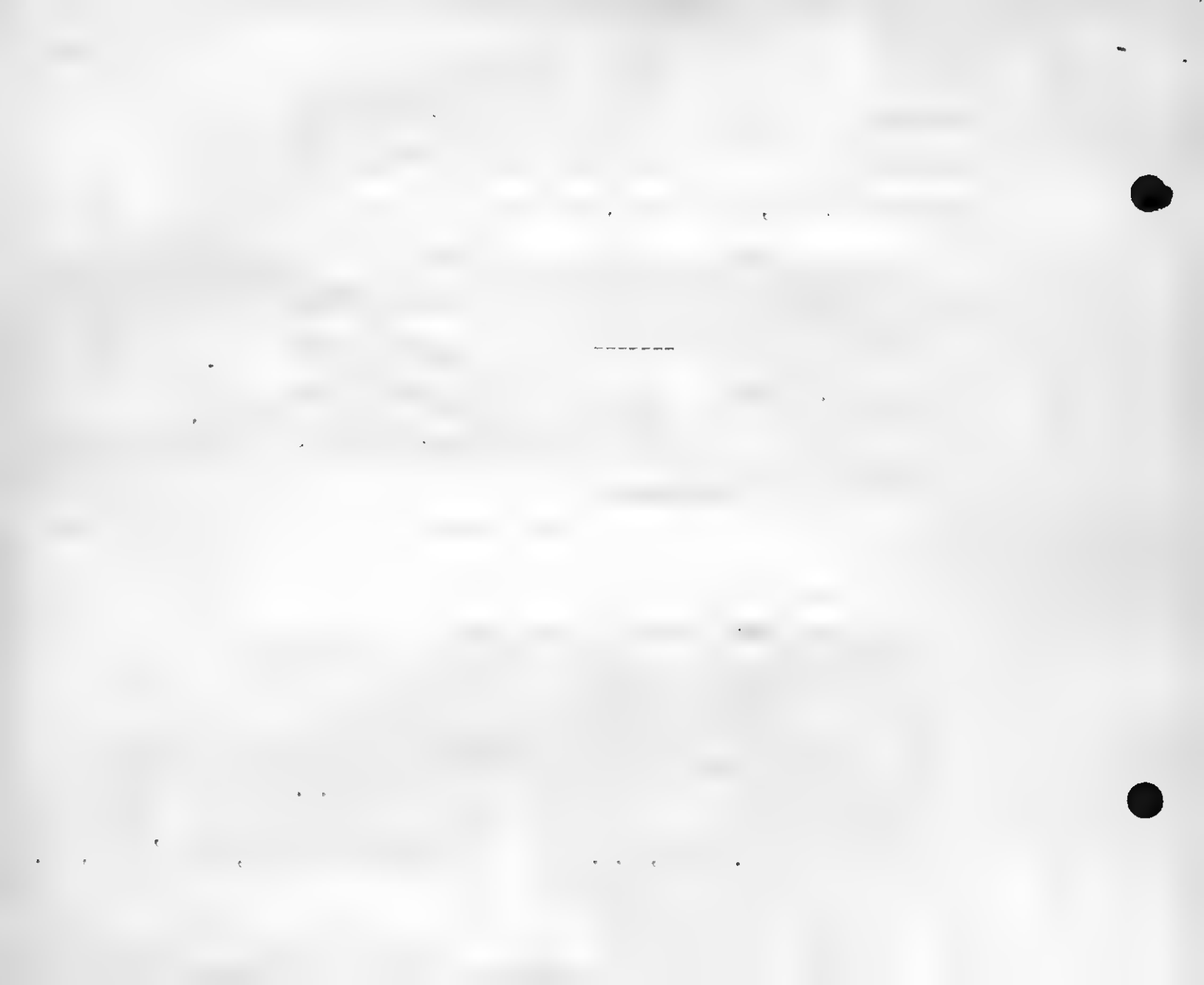
05607

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>37 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>same as #2 D</u>				d. STREET ADDRESS <u>7806 Maple Ridge Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carrie Mason Norfleet</u>				4. DATE OF DEATH Month Day Year <u>April 19 1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 10, 1887</u>	9. AGE (In years last birthday) <u>78</u> yrs.	10. FUNDERS 1 YEAR Months Days Hours Min. <u>7 9</u>	11. FUNDERS 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Amelia County, Virginia</u>	
13. FATHER'S NAME <u>William Lloyd Mason</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Knoll</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-46-5666</u>		17. INFORMANT <u>Maria N. Young</u> Address <u>5107 Benton, Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u> DUE TO (b) <u>MITRAL STENOSIS</u> DUE TO (c) <u>RHEUMATIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>50 YRS.</u> <u>60 YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARCINOMA BREAST - RIGHT - Post-op</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>MAR 9, 1964</u> to <u>APRIL 19, 1966</u> , that (I) (we) last saw the deceased alive on <u>APRIL 12, 1966</u> , and that death occurred at <u>6:32 M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert G. Angle</u>				22b. DATE SIGNED <u>APRIL 19, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert G. Angle M.D.</u>				22d. ADDRESS <u>5009 Del Ray Ave., Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 4/22/66</u>		23b. DATE THEREOF <u>4/22/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hollywood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Richmond, Va.</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey Bethesda, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 21 1966</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05610											
05608											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE North Dakota b. COUNTY Williams						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 220 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grenora						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Maryland					d. STREET ADDRESS Box 235			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Kevin			Middle Dean		Last Nygaard		4. DATE OF DEATH Month April		Day 11 Year 19 66		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 20 September 1956		9. AGE (In years last birthday) 9 yrs.		IF UNDER 1 YEAR Months 9 Days 11 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY Student		11. BIRTHPLACE (County & State, or foreign country) North Dakota			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Melvin E. Nygaard					14. MOTHER'S MAIDEN NAME Alma Lerbakken						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Records, The Clinical Center, Bethesda 14, Maryland						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 2045 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Acute Myelogenous Leukemia DUE TO (c) Meningeal Leukemia and hemorrhage										INTERVAL BETWEEN ONSET AND DEATH 5 days 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Meningeal Leukemia and hemorrhage										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (this hospital) attended the deceased from 3 September, 1965 , to 11 April, 19 66 , that (we) last saw the deceased alive on 11 April 19 66 , and that death occurred at 2:10 PM , from the causes and on the date stated above.											
22a. SIGNATURE Robert S. Brown					22b. DATE SIGNED 11 April 1966			22c. PHYSICIAN'S NAME (Type) Robert S. Brown, M.D.			
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 4/11/66			23b. DATE THEREOF 4/11/66		23c. NAME OF CEMETERY OR CREMATORY Grenora Cemetery			23d. LOCATION (City, town or county) (State) Grenora, N.D.			
24. FUNERAL DIRECTOR Robert A. Pumphrey					24a. ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR APR 13 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove burden papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
056011
056011
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>28 hrs.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Ainosuka</i>		4. DATE OF DEATH <i>4-6</i>		5. SEX <i>Male</i>		6. COLOR OR RACE <i>Japanese</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-15-82</i>		9. AGE (in years last birthday) <i>84</i> yrs.		10. IF UNDER 1 YEAR Months <i>4</i> Days <i>6</i> Hours <i>19</i> Min. <i>66</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Manager (Retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>store</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Japan</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Not Available</i>		14. MOTHER'S MAIDEN NAME <i>Not Available</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Hospital Records</i>	
17. INFORMANT <i>Hospital Records</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Atherosclerosis and</i> DUE TO (c) <i>Myocardial Insufficiency</i>		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>1-3</i> , 19 <i>66</i> , to <i>4-6</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>4-6</i> , 19 <i>66</i> , and that death occurred at <i>3:30</i> PM, from the causes and on the date stated above.		22a. SIGNATURE <i>Richard A. Edenbaum</i>	
22b. DATE SIGNED <i>4/7/66</i>		22c. PHYSICIAN'S NAME (Type) <i>Richard H. Edenbaum MD</i>		22d. ADDRESS <i>4700 Bradley Boulevard Chevy Chase Md.</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
23b. DATE THEREOF <i>April 11, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Delaware Water Gap</i>		23d. LOCATION (City, town or county) (State) <i>Delaware Water Gap Pa</i>		24. FUNERAL DIRECTOR <i>Arthur Walter, 254 Carroll N.W. DC</i>	
25a. REC'D BY REGISTRAR <i>APR 11 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. NAME OF CEMETERY OR CREMATORY <i>Delaware Water Gap</i>		25d. LOCATION (City, town or county) (State) <i>Delaware Water Gap Pa</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05610

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dickerson</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>22 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		d. STREET ADDRESS <i>R#2</i>	
3. NAME OF DECEASED (Type or print) First <i>Octavia</i> Middle Last <i>Conley</i>		4. DATE OF DEATH Month <i>April</i> Day <i>28</i> Year <i>1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/18/1898</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <i>68</i> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Fredricks Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Ernest Ambush</i>	
14. MOTHER'S MAIDEN NAME <i>J. Virginia Williams</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Failure (Congestive)</i> DUE TO (b) <i>Hypertensive Cardiovascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Post-operative Colon resection</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS A POSTMORTEM PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 .., to 19 .., that (I) (we) last saw the deceased alive on 19 .., and that death occurred at <i>2:48</i> AM, from the causes and on the date stated above			
22a. SIGNATURE <i>Dr. Miller</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REINTERMENT (Specify)		23b. DATE THEREOF <i>5-2-66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Lion, Barnesville, Md.</i>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>George R. Snowden</i>		25a. REC'D BY REGISTRAR <i>MAY -3 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

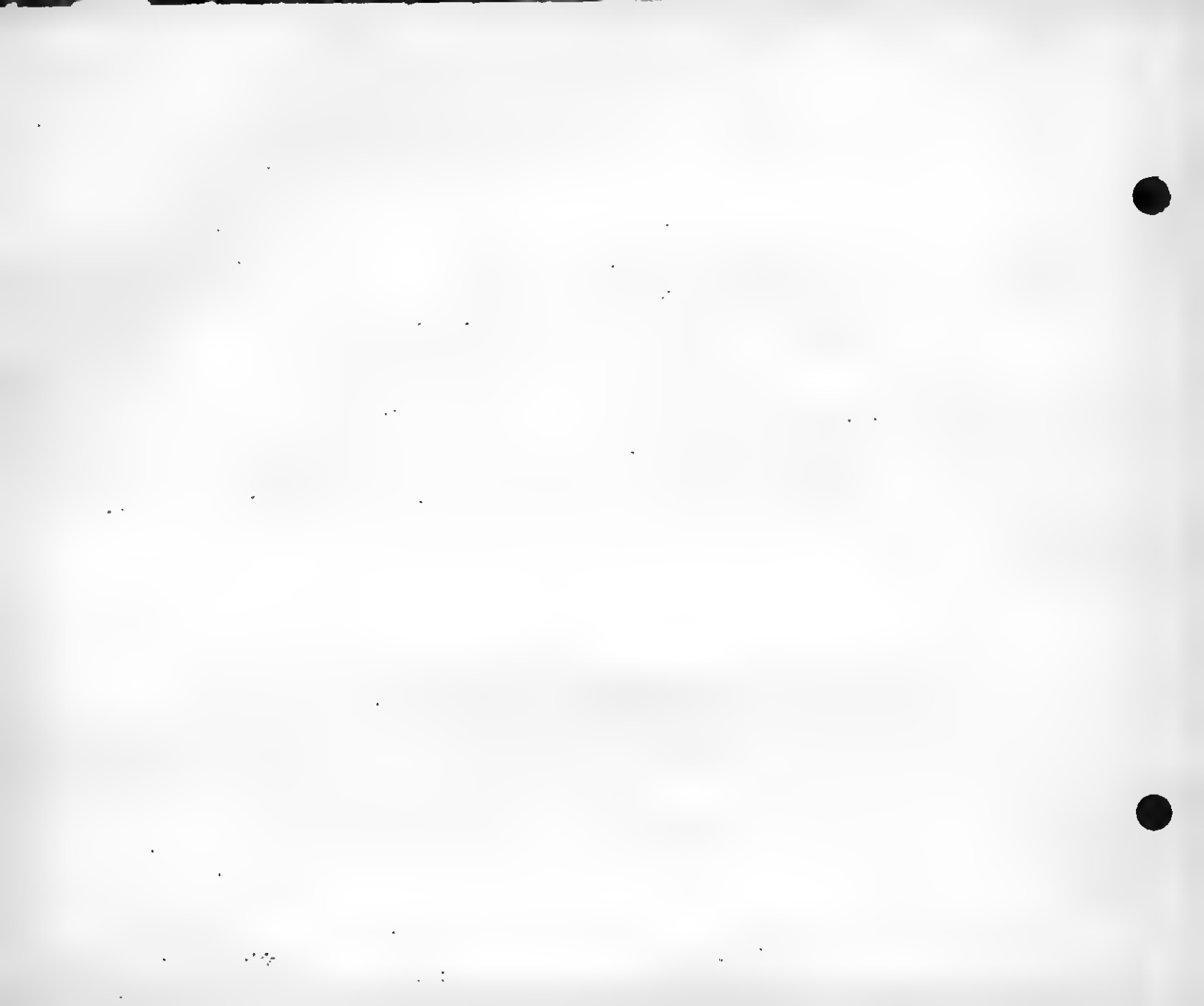
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any emit within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05613

05611

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN ID <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>606 Benington Drive</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>606 Benington Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Dorothy Jean Pappas</u> First Middle Last 4. DATE OF DEATH <u>April 16 1966</u> Month Day Year		5. SEX <u>Fe</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct. 26, 1924</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>41</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Beaver Falls, Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Richard L. Corvini</u>		14. MOTHER'S MAIDEN NAME <u>Anna Sonjak</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>234-32-1757</u>	
17. INFORMANT <u>George Pappas</u>		Address <u>606 Benington Drive Silver Spring, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon Monoxide Poisoning</u> 7/151 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Sat in car with motor running in closed garage</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:00 am April 16 1966</u> Hour am p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home garage</u> 20f. (City or town) (County) (State) <u>Silver Spring Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Bell</u> EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <u>4/16/66</u> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>20 April 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Arlington Virginia</u>	
24. FUNERAL DIRECTOR <u>Glen Barth</u> ADDRESS <u>8434 Georgia Avenue</u> <u>Warner E. Barth, Inc. Silver Spring, Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 22 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

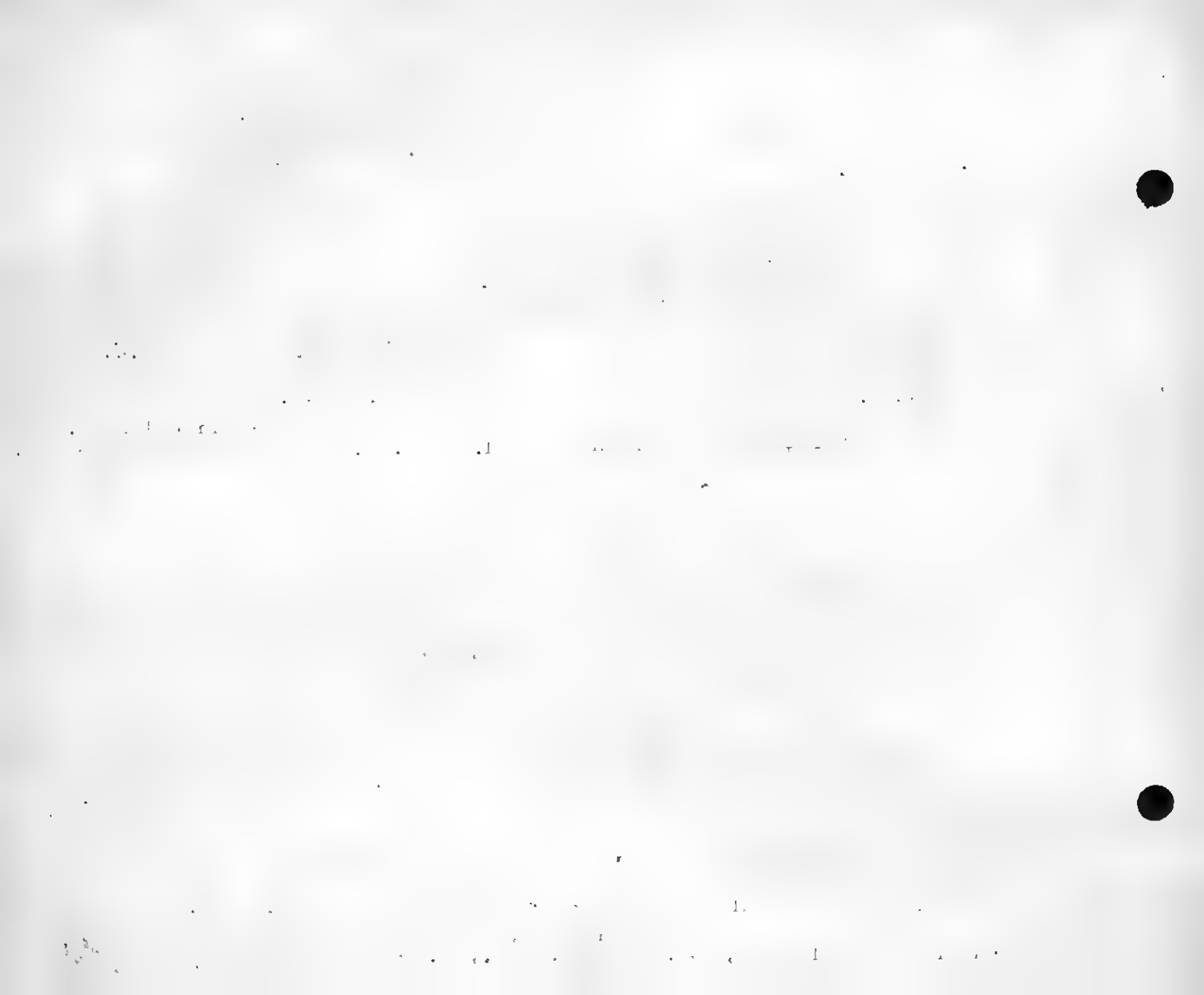


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WASHINGTON						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOLY CROSS Hospital.					d. STREET ADDRESS 6200 OREGON AVE N.W.						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First MARY Middle E Last PAYNE					4. DATE OF DEATH Month APR Day 27 Year 1966						
5. SEX F		6. COLOR OR RACE WH		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-16-84		9. AGE (In years last birthday) 81 yrs. IF UNDER 1 YEAR (If UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME John R. Eddins					14. MOTHER'S MAIDEN NAME Mary Whitehurst						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. ###-##-####		17. INFORMANT Col. Chas. B. Payne Address Springfield, Va. 8107 Smithfield Ave.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA in LUNGS. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) PLEURAL EFFUSIONS DUE TO (c) PULMONARY ATLECTOSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 26 APR 1966 , to 27 APR 1966 , that (I) (we) last saw the deceased alive on 26 APR 1966 , and that death occurred at 1:30 P M, from the causes and on the date stated above.											
22a. SIGNATURE Walter E. Booth					22b. DATE SIGNED 27 APR 66						
22c. PHYSICIAN'S NAME (Type) WALTER E. BOOTH					22d. ADDRESS 2390 GLENMONT CIR WHEATON MD						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 29 April 1966		23c. NAME OF CEMETERY OR GREMATORY Fairfax Memory Gardens		23d. LOCATION (City, town or county) (State) Fairfax, Va.				
24. FUNERAL DIRECTOR Rinaldi Funeral Home, Inc. 7400 Ga. Ave., N. Washington, DC					25a. REG'D BY REGISTRAR MAY 2 1966		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05615

05613

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens</u>		d. STREET ADDRESS <u>4427 Potomac Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Esther</u> Middle <u>M.</u> Last <u>PERRY</u>		4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 28, 1890</u>
9a. AGE (in years last birthday) <u>75</u> yrs.		9b. IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Navy Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US NAVY</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Georgetown D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM F. KNOTT</u>		14. MOTHER'S MAIDEN NAME <u>MARY L. HURLEY</u>	
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-26-3899-D</u>	
17. INFORMANT <u>FRANCES E. BOYLE</u>		Address <u>4508 MACARTHUR BLVD N.W.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>general Vascular failure</u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive heart disease - 3 years</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>40</u> to <u>April 30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>April 29</u> , 19 <u>66</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert E. Maher</u>		22b. DATE SIGNED <u>5/1/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert E. Maher MD</u>		22d. ADDRESS <u>1835 Eye St. N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5/4/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION</u>	23d. LOCATION (City, town or county) (State) <u>MONTGOMERY CO. MD.</u>
24. FUNERAL DIRECTOR <u>new Chamber Co.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAY 5 1966</u>	

CERTIFICATE OF DEATH

05614

05616

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Giney		c. LENGTH OF STAY IN 1b 26 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS Dayton	
3. NAME OF DECEASED (Type or print) First George Middle Elwood Last Phelps		4. DATE OF DEATH Month 4-29-66 Day 19 Year 19	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-5-11
9. AGE (In years last birthday) 55 yrs		10. IF UNDER 1 YEAR Months 1 Days 1	11. IF UNDER 24 HRS Hours 1 Min. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) water plant operator		10b. KIND OF BUSINESS OR INDUSTRY Wash. Sub. San. Com.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis A. Phelps		14. MOTHER'S MAIDEN NAME Mary E. Hill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 218-12-7376	
17. INFORMANT Hospital Admission Record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia DUE TO Bronchogenic carcinoma with metastases to spine, brain, liver, and kidneys Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH 1 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) physician attended the deceased from 10-18-1946 to 4-29-1966 , that (I) (ye) saw the deceased alive on 4-28-1966 , and that death occurred at 1:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE Charles S. Whitaker, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 4-29-66
22c. PHYSICIAN'S NAME (Type) Charles S. Whitaker, M. D.		22d. ADDRESS Clarksville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-2-1966	23c. NAME OF CEMETERY OR CREMATORY Mt. View	23d. LOCATION (City or Town) (County) (State) Alpha, Md
24. FUNERAL DIRECTOR F.C. Higginbotham, Ellicott City, Md		25a. REC'D BY REGISTRAR MAY 2 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

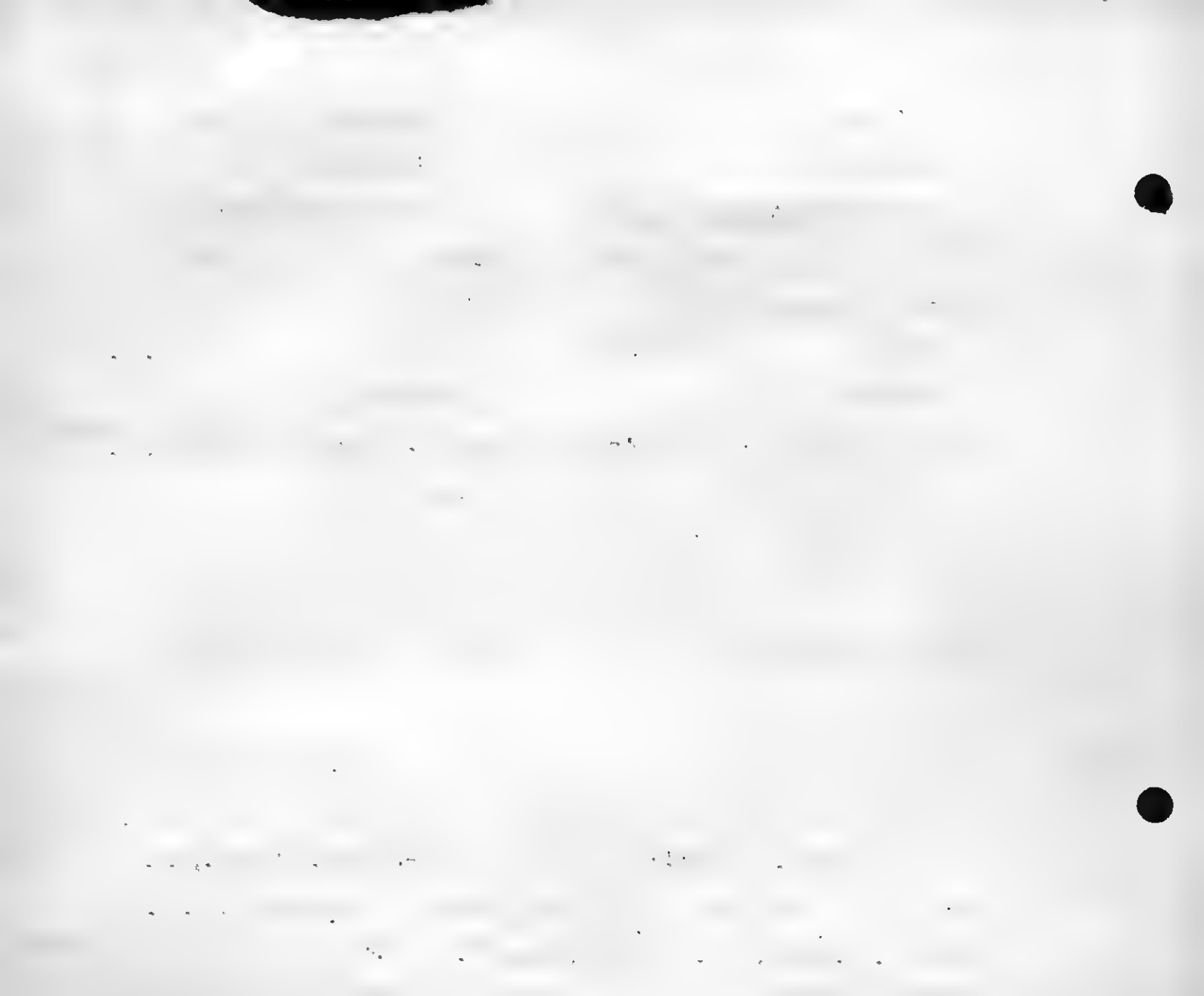
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05617											
05615											
1. PLACE OF DEATH e. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GERMAN TOWN</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Marylander Home of Rest, Inc.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> d. STREET ADDRESS <u>13804 Bauer Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>JOHANNA P. Pielich</u> First Middle Last 4. DATE OF DEATH <u>4 26 1966</u> Month Day Year						5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>12/27/1879</u> 9. AGE (In years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HAT DESIGNER</u>						10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (County & State, or foreign country) <u>Yugoslavia</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>Perne</u>						14. MOTHER'S MAIDEN NAME <u>Ursula</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)						16. SOCIAL SECURITY NO. <u>158-10-2343</u>					
17. INFORMANT <u>P. Saville</u>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>interior aortic cardiovascular disease</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office b.d.g., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) <u>(not present)</u> attended the deceased from <u>9/28</u> 19 <u>65</u> to <u>4/26</u> 19 <u>66</u> , that (I) <u>(not)</u> saw the deceased alive on <u>4/27</u> 19 <u>66</u> , and that death occurred at <u>7:15 AM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>James P. Kerr</u> 22c. PHYSICIAN'S NAME (Type) <u>James P. Kerr</u>						22b. DATE SIGNED <u>4/26/66</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>DAMASCUS, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>4/27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>				23d. LOCATION (City, town or county) (State) <u>Silver Spring, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u> ADDRESS <u>13-1 Rockville Pike Rockville, Maryland</u>						25a. REC'D BY REGISTRAR <u>MAY 2 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05618					CERTIFICATE OF DEATH				
					37219				
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>District of Columbia</i> b. COUNTY <i>Washington</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>			c. LENGTH OF STAY IN ID <i>1 1/2 Days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium & Hospital</i>					d. STREET ADDRESS <i>54 Nicholson Street NW</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Marcia Ethel Pierson</i>					4. DATE OF DEATH Month Day Year <i>April 30 1966</i>				
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Caucasian</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-6-1883</i>		9. AGE (In years last birthday) <i>82</i> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John Robey</i>					14. MOTHER'S MAIDEN NAME <i>Emma Bosye</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>578-28-47238</i>		17. INFORMANT <i>Joseph W. Pierson</i>			Address <i>54 Nicholson Street, NW Washington, D. C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>congestive heart failure</i> <i>4200</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic heart disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>10 years</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>10 April 1966</i> to <i>30 April 1966</i> , that (I) (we) last saw the deceased alive on <i>30 April 1966</i> , and that death occurred at <i>4:45 PM</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>John D. Griswold, MD.</i>					22b. DATE SIGNED <i>May 1, 1966</i>			22c. PHYSICIAN'S NAME (Type) <i>John D. Griswold MD</i>	
22d. ADDRESS <i>1601-16th St. NW Wash., D.C.</i>					22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>4 May 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Washington, D. C.</i>	
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>					25a. REC'D BY REGISTRAR <i>May 10 1966</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and if any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
05619													
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>5 DAYS 9 HRS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. SAN & Hosp</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Mont</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>1029 QUEBEC TERRACE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>(N)</u> Last <u>Peniston</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>20</u> Year <u>1966</u>			5. SEX <u>M</u>			6. COLOR OR RACE <u>W</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>4-11-10</u>			9. AGE (In years last birthday) <u>56</u> yrs. Months <u>5</u> Days <u>10</u> Hours <u>15</u> Min.			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>				
10b. KIND OF BUSINESS OR INDUSTRY <u>BOOKSTORE</u>			11. BIRTHPLACE (County & State, or foreign country) <u>PENNA.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			13. FATHER'S NAME <u>BENT - PRAEFINGER</u>				
14. MOTHER'S MAIDEN NAME <u>ROSE LISS</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>198-03-6699</u>			17. INFORMANT <u>Hosp. Records</u> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary Edema</u> <u>4301</u> DUE TO (b) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Severe Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Myocarditis</u>												INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>6/13</u> , 19 <u>65</u> , to <u>6/20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/20</u> , 19 <u>66</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Raymond O. West</u>						22b. DATE SIGNED <u>4-21-66</u>			22c. PHYSICIAN'S NAME (Type) <u>RAYMOND O. WEST M.D.</u>				
22d. ADDRESS <u>831 UNIVERSITY BLVD E. S.S. MD</u>						23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>4-24-66</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Stav-Nebor</u>						23d. LOCATION (City, town or county) (State) <u>Chila, Penna</u>			24. FUNERAL DIRECTOR <u>Ernest E. Humphrey, Inc.</u> ADDRESS <u>8434 Gilbre</u>				
25a. RECEIVED BY REGISTRAR <u>APR 25 1966</u>						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
05620					05617									
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NHEATON</u> d. STREET ADDRESS <u>3715 May Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>SEAN</u> First <u>CARLOS PRENTISS</u> Middle <u>LAST</u> Last			4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1966</u>											
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/11/64</u>		9. AGE (In years last birthday) <u>1</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINDER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MONTGOMERY - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						
13. FATHER'S NAME <u>JAMES L. PRENTISS</u>					14. MOTHER'S MAIDEN NAME <u>Betty SEDBERRY</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) <u>None</u>					16. SOCIAL SECURITY NO. <u>None</u>					17. INFORMANT <u>Betty & James Prentiss</u> Address <u>3715 May Street Nheaton, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Hemophilia, Classical (Factor VIII Deficiency)</u> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <u>34 days</u>				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>9-11</u> , 19 <u>64</u> , to <u>4-13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4-13</u> 19 <u>66</u> , and that death occurred at <u>6:30</u> AM, from the causes and on the date stated above.														
22a. SIGNATURE <u>Stanley I. Wolf</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <u>4-13-66</u>									
22c. PHYSICIAN'S NAME (Type) <u>Stanley I. Wolf, MD</u>					22d. ADDRESS <u>1110 Spring St., Silver Spring, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>15 April 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince George Co., Md.</u>								
24. FUNERAL DIRECTOR <u>John A. Thomas</u> ADDRESS <u>8434 Georgia Avenue</u>					25a. REC'D BY REGISTRAR <u>APR 18 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							
Warner E. Humphrey, Inc. Silver Spring, Maryland														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <u>MARYLAND</u> c. COUNTY <u>MONTGOMERY</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>17 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>POOLESVILLE</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FAIRLAND Nursing Home</u>						e. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>-</u> Last <u>PROBST</u>						4. DATE OF DEATH Month <u>APR</u> Day <u>5</u> Year <u>1966</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 26 1881</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCH MAKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>FRANKLIN W. VA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FELIX PROBST</u>						14. MOTHER'S MAIDEN NAME <u>BARBARA HOOVER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>229-03-8563</u>		17. INFORMANT <u>PSingley R.N. 2101 FAIRLAND RD Silver Spring MD</u>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u> 40115 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>4RS.</u> <u>4RS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3/19</u> , 19 <u>66</u> , to <u>4/5</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/5</u> , 19 <u>66</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Raymond T. Benack MD</u>						22b. DATE SIGNED <u>4/5/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Raymond T. BENACK MD</u>		22d. ADDRESS <u>4115 Colie Drive Wheaton MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>4/8/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Monterey Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>McDowell Virginia</u>			
24. FUNERAL DIRECTOR <u>J. Wm. Lees Sons 300 4th St., NE, Wash. DC</u>						25a. REC'D BY REGISTRAR <u>APR 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05622

05619

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase, Md.</u>			
c. LENGTH OF STAY IN ID <u>440.10 months</u>				d. STREET ADDRESS <u>3904 Blackthorn Street</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Leomis</u> Last <u>Ray</u>				4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 6, 1884</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUSINESS EXEC.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (County & State, or foreign country) <u>PENNA.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Joseph Martin Ray</u>			
14. MOTHER'S MAIDEN NAME <u>SARAH Paulding</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <u>085-03-4286</u>				17. INFORMANT Address <u>COLE RAY, 280 OAK ST., RIDGEWOOD N.J.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> <u>493x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6 APRIL, 1966</u> to <u>13 APRIL, 1966</u> ; that (I) (we) last saw the deceased alive on <u>12 APR 1966</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>13A 66</u>			
22c. PHYSICIAN'S NAME (Type) <u>WALTER GOOZ H MD</u>				22d. ADDRESS <u>2390 GLENMONT CIR HEATON MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-18-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WINDY COVE CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>MILBORO SPRINGS, VA.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>JOS. GAWLER'S SONS, 5130 WIS AVENUE, N.W., WASH. D.C.</u>				25a. REC'D BY REGISTRAR <u>APR 18 1966</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

05623

CERTIFICATE OF DEATH

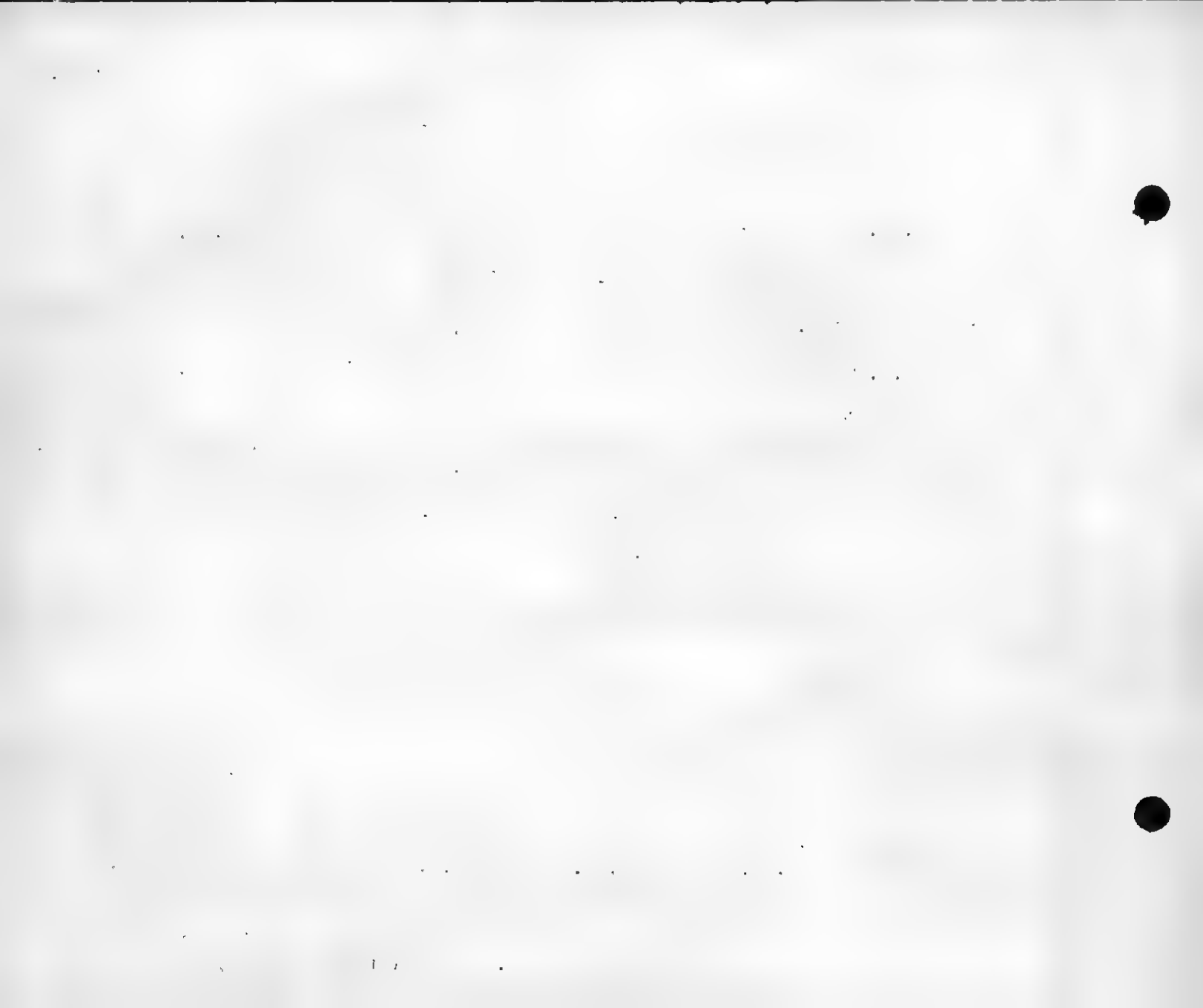
05620

1 PLACE OF DEATH a. COUNTY Montgomery		b. STATE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN ID 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 3801 Yuma Street, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) James Edward REICH		4 DATE OF DEATH Month April Day 1 Year 1966			
5 SEX Male	6. COLOR OR RACE Cauc.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 4, 1878	9. AGE (In years last birthday) 87 yrs	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Winston-Salem, North Car	
13. FATHER'S NAME James Alexander Reich		14. MOTHER'S MAIDEN NAME Paulina Miller		12 CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1900-		16. SOCIAL SECURITY NO 79-60-3735		17. INFORMANT PKWY. Washington, D. C. Mrs. Kathleen Cooney, 5607 Chevy Chase/	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4300 Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Arteriosclerotic heart disease DUE TO (b) (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture pelvis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I (this hospital) attended the deceased from Mar. 28 , 19 66 , to Apr. 1 , 19 66 , that I (we) lost saw the deceased alive on April 1 , 19 66 , and that death occurred at 135PM , from causes and on the date stated above					
22a. SIGNATURE S. J. Barcay		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED April 1, 1966	
22c. PHYSICIAN'S NAME (Type) S. J. Barcay, M. D.		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF APR. 5, 1966	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24 FUNERAL DIRECTOR HANLON FUNERAL HOME		ADDRESS 4748 WISCONSIN AVE. Washing		25a. REC'D BY REGISTRAR APR 12-1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR #15 (4)
 20M 1/65

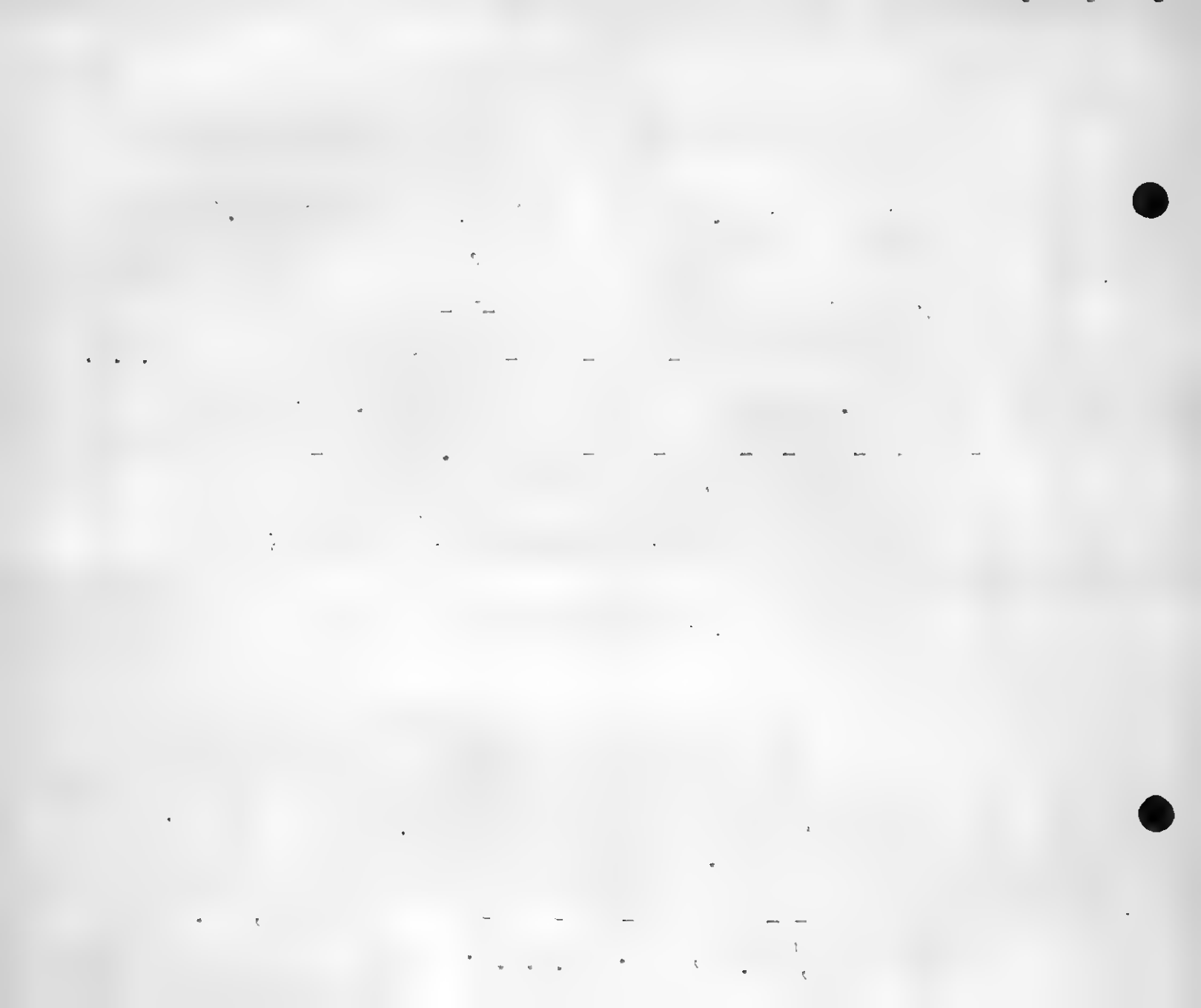
05624

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05624

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5707 Ridgfield Rd. (Springfield)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RUTH Middle Last RESSER				4. DATE OF DEATH Month April Day 3 Year 1966							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-11-1892		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (County & State, or foreign country) - Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Alfred D. Evans				14. MOTHER'S MAIDEN NAME Mary K. Landis							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) - - -				16. SOCIAL SECURITY NO. - - -		17. INFORMANT Ida A. Coffey - See Item #2(above)				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Atherosclerotic Cardiovascular Disease DUE TO (c) Diabetes Mellitus								INTERVAL BETWEEN ONSET AND DEATH 24 hrs over 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Nov 8, 1965 , to April 3, 1966 , that (I) was last saw the deceased alive on Mar 31, 1966 , and that death occurred at 7:50 PM , from the causes and on the date stated above.											
22a. SIGNATURE Michel M. Healy								22b. DATE SIGNED 4/4/66			
22c. PHYSICIAN'S NAME (Type) Michel M. Healy								22d. ADDRESS Washington Clinic, Wash D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE THEREOF 4-6-1966		23c. NAME OF CEMETERY OR CREMATORY - - -		23d. LOCATION (City, town or county) (State) Leola, Pa.			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.								25a. REC'D BY REGISTRAR APR 7 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge	

Washington, DC. Ave. N.W. 5130 Wisc.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05625

05622

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a STATE Virginia b COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c LENGTH OF STAY IN Tb 32 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital		d STREET ADDRESS 3561 South Stafford Street	
3. NAME OF DECEASED (Type or print) First Frank Middle Faries Last REYNOLDS		4. DATE OF DEATH Month April Day 11 Year 19 66	
5 SEX Male	6 COLOR OR RACE Cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 29, 1890
9 AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min 75	IF UNDER 24 HRS Hours 75 Min 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) Clayton, Delaware
12 CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frank Lincoln Reynolds	
14. MOTHER'S MAIDEN NAME Laura Faries		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1911-1945	
16 SOCIAL SECURITY NO 577 46 7295		17 INFORMANT St. Arlington, Va. Mrs. Clarita C. Reynolds, 3561 S. Stafford/	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchogenic carcinoma with metastases 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 10, 1966 to April 11, 1966 , that (I) (we) last saw the deceased alive on April 11, 1966 , and that death occurred at 1034 PM , from causes and on the date stated above			
22a. SIGNATURE Francis C. Johnson		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED April 12, 1966
22c. PHYSICIAN'S NAME (Type) Francis C. Johnson, M. D.		22d ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 4-13-66	23c. NAME OF CEMETERY OR CREMATORY Lees Crematory	23d. LOCATION (City or Town) (County) (State) Washington, D. C.
24. FUNERAL DIRECTOR James Funeral Home, 520 South Washington St		25a REC'D BY REGISTRAR APR 14 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.



CERTIFICATE OF DEATH

05626

05623

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Chevy Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>4605 High St</u>	
3 NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>M.</u> Last <u>Richmond</u>		DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>Cauc</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12/20/73</u>
9 AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hours <u>66</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>CHARLES T. GRIMES</u>		14. MOTHER'S MAIDEN NAME <u>MARY E. PYLES</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>— —</u>	
17. INFORMANT <u>FORREST G. GRIMES, -4731 ALTON PL. N.W.</u>		Address <u>WASHINGTON D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL PNEUMONIA</u> <u>260X</u> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ARTERIO-SCLEROSIS & THYROID TUMOR</u> DUE TO (c) <u>DIABETES MELLITUS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 HRS</u> <u>6 RADICAL</u> <u>3 YRS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE, 1950</u> , to <u>APRIL, 1966</u> , that (I) (we) last saw the deceased alive on <u>4/5</u> 19 <u>66</u> , and that death occurred at <u>6:19</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph I Donovaw M.D.</u> M.D.		22b. DATE SIGNED <u>4/5/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH I DONOVAN M.D.</u>		22d. ADDRESS <u>8218 WISCONSIN AVE BETHESDA 14 MARYLAND</u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>4-8-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR <u>JOSEPH AWLERS SONS</u>		25a. REC'D BY REGISTRAR <u>WASHINGTON</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>APR 7 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

05627

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05624

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN IB 4 Months		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 9512 Seddon Court	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9512 Seddon Court				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARION Middle CLAUDE Last RISER				4. DATE OF DEATH Month April Day 6 Year 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 14, 1878	9. AGE (In years last birthday) 88	IF UNDER 1 YEAR Months 0 Days 22	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James H. Riser				14. MOTHER'S MAIDEN NAME Elizabeth Etheredge			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 		17. INFORMANT Daughter Address Mrs. Mary R. Schaeffer Same as Item 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic cardiovascular disease DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Auricular fibrillation							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	
20f. (City or town) (County) (State) 		21. I certify that (1) (this hospital) attended the deceased from Feb. 18, 1966 , to April 6, 1966 , that (1) (we) last saw the deceased alive on April 1, 1966 , and that death occurred at 8 P M, from the causes and on the date stated above.					
22a. SIGNATURE Alfred S. Norton				22b. DATE SIGNED April 7 1966		22c. PHYSICIAN'S NAME (Type) ALFRED S. NORTON	
22d. ADDRESS 7710 Dwight Dr., Bethesda, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit					
23b. DATE THEREOF 4-7-66		23c. NAME OF CEMETERY OR CREMATORY Rosemont Cemetery		23d. LOCATION (City, town or county) (State) Newberry, South Car.		23e. REC'D BY REGISTRAR APR 11 1966	
23f. REGISTRAR'S SIGNATURE Charles Judge		24. FUNERAL DIRECTOR ROBERT A. PUMPHREY Bethesda, Maryland					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 7, MARYLAND

CERTIFICATE OF DEATH

05628

05625

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg Md.				c. LENGTH OF STAY IN 1b 1 Month			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pleasant View Nursing Home				e. STREET ADDRESS 35 W. Bethel Street			
3. NAME OF DECEASED (Type or print) First Middle Last David Lewis Robinson				4. DATE OF DEATH Month Day Year April 23 19 66			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 14 1893	
9. AGE (In years last birthday) 72 yrs.		10. FUND 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Martinsburg W. Va		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook				10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (County & State, or foreign country) Martinsburg W. Va	
13. FATHER'S NAME David H. Robinson				14. MOTHER'S MAIDEN NAME Sallie E. Banks			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 233-40-9561		17. INFORMANT Address Mrs. Genevieve R. McClain	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 500X DUE TO (b) Acute Bronchitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 2nd & 3rd degree Burn of leg							INTERVAL BETWEEN ONSET AND DEATH 1 wk 1 wk 2 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 23 Apr , 19 66 , that (I) (we) last saw the deceased alive on 23 Apr , 19 66 , and that death occurred at 8:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE [Signature]				22b. DATE SIGNED 24 Apr 1966		22c. PHYSICIAN'S NAME (Type) [Signature]	
22d. ADDRESS [Signature]				22e. ADDRESS [Signature]			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-28-1966		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR John R Watson Jr Hagerstown Md.				25a. REC'D BY REGISTRAR [Signature]			
25b. REGISTRAR'S SIGNATURE [Signature]				DATE APR 26 1966			

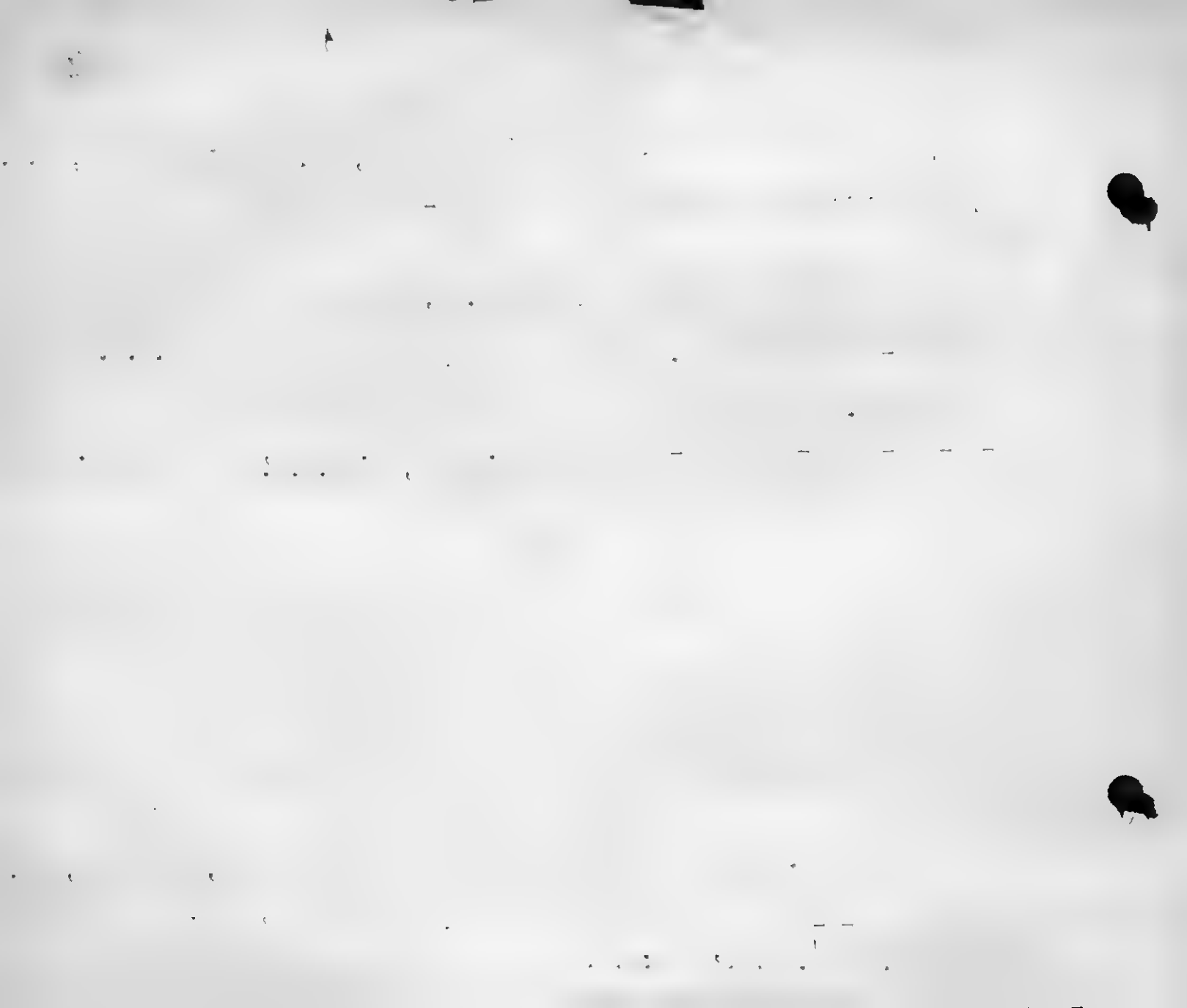


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN IT 21 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RESMOR SANITARIUM & HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROOKMONT, MD. WASHINGTON 16, D.C. d. STREET ADDRESS 4006- 62nd STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROSA First R Middle ROGERS Last 4. DATE OF DEATH APRIL Month 6 Day 19 66 Year		5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH SEPT. 5, 1879 9. AGE (In years last birthday) 86 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last year or work in the case of retired) FITTER - (Retired) 10b. KIND OF BUSINESS OR INDUSTRY Dept. Store 11. BIRTHPLACE (County & State, or foreign country) SOUTH CAROLINA 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSIAH T. RICKENBAKER 14. MOTHER'S MAIDEN NAME MARY ELIZABETH PATRICK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 578-03-2463/ 17. INFORMANT Mrs. Hazel B. Kyber, 4006 62nd St. Brookmont, Wash. D.C. Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra Abdominal Neoplasm 1550 DUE TO Conditions, if any, which gave rise to immediate cause (b) -Primary in Cecum (c) DUE TO (e), stating the underlying cause last. PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bleeding Gastro Ulcer Multiple Pulmonary Emboli Arterio Lobular Pneumonia 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Jan 1963 to 4-6-66 that (I) (we) last saw the deceased alive on 3-25-66 and that death occurred at 1:30 PM , from the causes and on the date stated above.	
22a. SIGNATURE Paul D. Cantor M.D. 22b. DATE SIGNED 4/6/66 22c. PHYSICIAN'S NAME (Type) PAUL D. CANTOR		22d. ADDRESS 4709 Montgomery Lane, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4-9-1966 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery 23d. LOCATION (City, town or county) (State) Suitland, Md.		24. FUNERAL DIRECTOR'S SIGNATURE Joseph C. Lawler's Sons, Inc. ADDRESS 5130 Wisc. Ave. N.W., Wash. D.C. 25a. REC'D BY REGISTRAR APR 11 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
05627									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 182 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Elkins Park c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 841 Jenkintown d. STREET ADDRESS 841 Jenkintown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Morton Alexander Rosenfeld					4. DATE OF DEATH Month Day Year April 13 1966				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 January 1923		9. AGE (In years last birthday) 43 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager		10b. KIND OF BUSINESS OR INDUSTRY Metal stand company Connecticut		11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel Rosenfeld	
13. FATHER'S NAME Samuel Rosenfeld		14. MOTHER'S MAIDEN NAME Sarah Marcus		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1941-45		16. SOCIAL SECURITY NO. Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md. 20014	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pericarditis and myocarditis 143 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral pneumonitis (c) Acute myelogenous leukemia								INTERVAL BETWEEN ONSET AND DEATH 30 days 10 days 13 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from 13 October 1965 , to 13 April 1966 , that he (we) last saw the deceased alive on 13 April 1966 , and that death occurred at 1245M , from the causes and on the date stated above.									
22a. SIGNATURE Herman A. Godwin, Jr. 22c. PHYSICIAN'S NAME (Type) Herman A. Godwin, M.D.					22b. DATE SIGNED 14 April 1966 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-15-66		23c. NAME OF CEMETERY OR CREMATORY King David Cem.		23d. LOCATION (City, town or county) (State) Bucks. Co. Penna.			
24. FUNERAL DIRECTOR Goldberg Funeral Home ADDRESS 4217 9th St. Wash. D.C.					25a. REC'D BY REGISTRAR APR 18 1966 25b. REGISTRAR'S SIGNATURE Charles J. [Signature]				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

15631

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15628

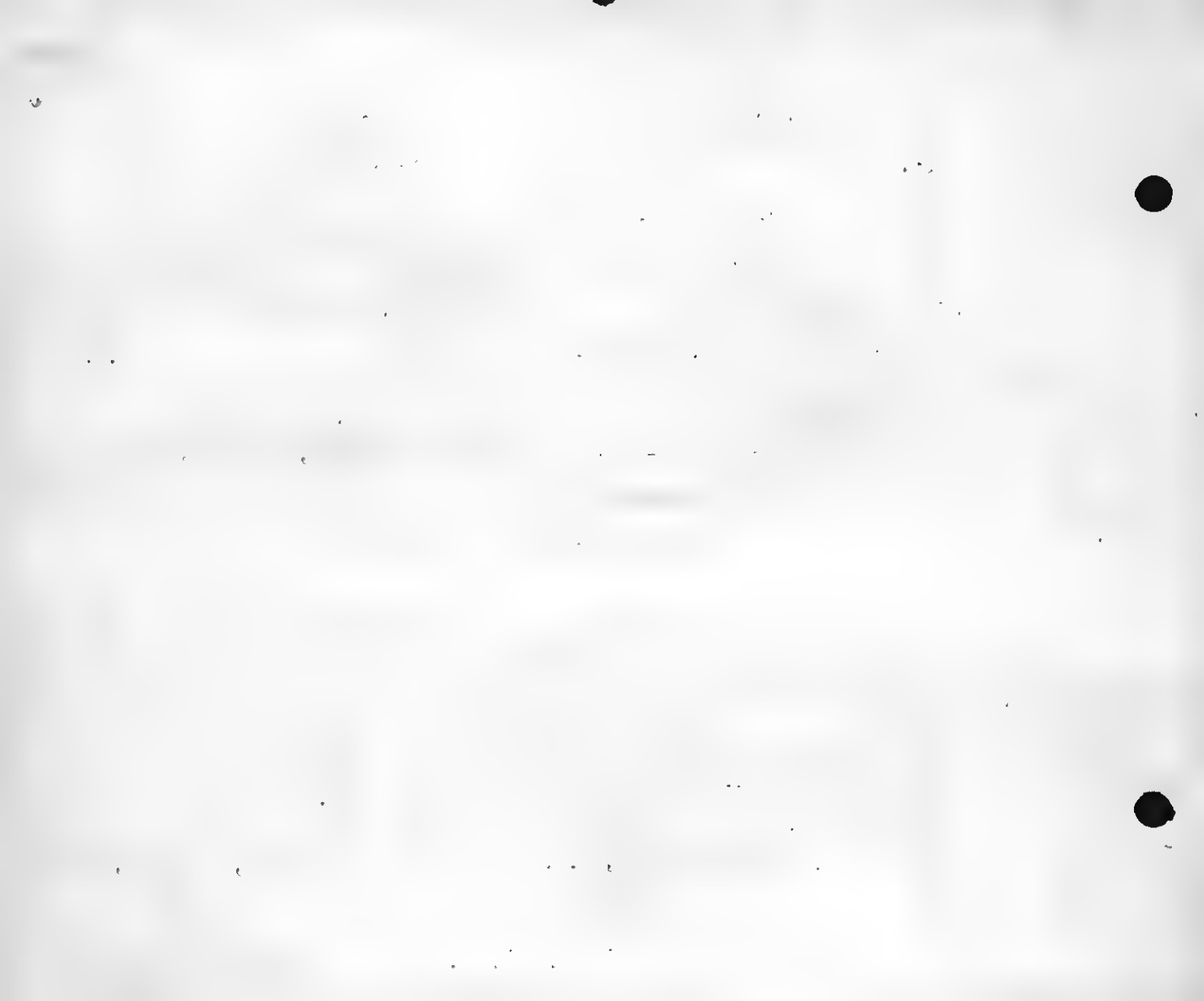
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> c. LENGTH OF STAY IN 1b <u>5 Months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairland Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>3938 LANTERN DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Hattie</u> First <u>Rosenthal</u> Middle <u>Rosenthal</u> Last 4. DATE OF DEATH <u>April</u> Month <u>27</u> Day <u>19</u> Year <u>1966</u>				5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>8/31/1894</u> 9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> 11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>LOUIS JACOBS</u> 14. MOTHER'S MAIDEN NAME <u>ROSE PRICE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>MR. ABRAHAM ROSENTHAL</u> Address <u>3938 LANTERN DRIVE SILVER SPRING, MD</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>CEREBRAL THROMBOSIS</u> DUE TO <u>ARTERIOSCLEROSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>7-8 DAYS</u> <u>6405</u> <u>12 YRS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that (I) (this-hospital) attended the deceased from <u>9/5</u> to <u>4/27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/21</u> , 19 <u>66</u> , and that death occurred at <u>2:55</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> 22b. DATE SIGNED <u>4/27/66</u> 22c. PHYSICIAN'S NAME (Type) <u>Harold S. Berkman</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>1352 UNIV BLVD</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>4/28/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>JEWISH WAR VETERANS MEMORIAL</u> 23d. LOCATION (City, town or county) (State) <u>ROSEDALE, MARYLAND</u>			
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC.</u> ADDRESS <u>6010 REISTERSTOWN ROAD</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				DATE <u>APR 28 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda					c. LENGTH OF STAY IN ID 41 days				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland					d. STREET ADDRESS 8504 Tahoma Drive				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Henry Middle (none) Last Rosenthal					4. DATE OF DEATH Month April Day 21 Year 1966				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 22, 1892		9. AGE (In years last birthday) 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Worker		10b. KIND OF BUSINESS OR INDUSTRY unascertainable		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Isaac Rosenthal					14. MOTHER'S MAIDEN NAME Fannie Wier				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes					16. SOCIAL SECURITY NO. 579-28-6940				
17. INFORMANT The Medical Records					Address The Clinical Center, Bethesda, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypercalcaemia 1040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) Chronic Lymphocytic Leukemia c) 6 years									INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (X) (this hospital) attended the deceased from March 11, 1966 , to April 21, 1966 , that (X) (we) last saw the deceased alive on April 21, 1966 , and that death occurred at 3:55M , from the causes and on the date stated above.									
22a. SIGNATURE Alexander Levitan					A. M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 21 April 1966	
22c. PHYSICIAN'S NAME (Type) Alexander Levitan, M.D.					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/24/66		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden Falls Church, Virginia		23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR Bernard Danzansky & Sons					25a. REC'D BY REGISTRAR APR 25 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> </div> <div> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>05630</p> </div> </div>																																		
<p>1. PLACE OF DEATH</p> <p>a. COUNTY Montgomery MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda</p> <p>c. LENGTH OF STAY IN ID 42 days</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland</p>					<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE Pennsylvania b. COUNTY ✓</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Uniontown</p> <p>d. STREET ADDRESS Route # 2, Box 368</p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>																													
<p>3. NAME OF DECEASED (Type or print)</p> <p>First Robert Middle Richard Last Ross</p>			<p>4. DATE OF DEATH</p> <p>Month April Day 16 Year 19 66</p>		<p>5. SEX Male</p>			<p>6. COLOR OR RACE White</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 30 January 1943</p>		<p>9. AGE (In years last birthday) 23 yrs.</p>		<p>IF UNDER 1 YEAR Months 23 Days 23 Hours 23 Min.</p>		<p>IF UNDER 24 HRS. Hours 23 Min.</p>																
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer</p>					<p>10b. KIND OF BUSINESS OR INDUSTRY Construction</p>					<p>11. BIRTHPLACE (County & State, or foreign country) Ohio</p>					<p>12. CITIZEN OF WHAT COUNTRY? USA</p>																			
<p>13. FATHER'S NAME Thomas Ross</p>										<p>14. MOTHER'S MAIDEN NAME Anna May Stanley</p>																								
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No</p>					<p>16. SOCIAL SECURITY NO. Unascertainable</p>					<p>17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md. 20014</p>																								
MEDICAL CERTIFICATION															<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Epistaxis secondary to thrombocytopenia</p> <p>2043 DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.</p> <p>(b) Acute Myelogenous Leukemia</p> <p>DUE TO</p> <p>(c)</p>										<p>INTERVAL BETWEEN ONSET AND DEATH 43 days</p>									
															<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>															<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>				
															<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>					<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>														
															<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour e.m. 19 p.m.</p>					<p>20d. INJURY OCCURRED</p> <p>While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></p>					<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>					<p>20f. (City or town) (County) (State)</p>				
<p>21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 5, 19 66, to April 16, 19 66, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 16, 19 66, and that death occurred at 9:55 M. from the causes and on the date stated above.</p>																																		
<p>22a. SIGNATURE Berton Zbar</p>										<p>22b. DATE SIGNED 16 April 1966</p>																								
<p>22c. PHYSICIAN'S NAME (Type) Berton Zbar, M.D.</p>										<p>22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland</p>																								
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 4-17-66</p>					<p>23b. DATE THEREOF</p>					<p>23c. NAME OF CEMETERY OR CREMATORY White Rock Cemetery</p>					<p>23d. LOCATION (City, town or county) (State) Fairchance, Penna.</p>																			
<p>24. FUNERAL DIRECTOR ROBERT A. PUMPHREY ADDRESS Bethesda, Maryland</p>										<p>25a. REC'D BY REGISTRAR APR 21 1966</p>					<p>25b. REGISTRAR'S SIGNATURE J. Charles Judge</p>																			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05634

05631

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE	
c. LENGTH OF STAY IN 1b 15 yrs		d. STREET ADDRESS 2821-SPENCER Rd.	
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethesda Silver Spring Nursing Home		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FANNIE First Middle Last		4. DATE OF DEATH RUDNER Month APRIL Day 25 Year 1966	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/14/1876
9. AGE (In years last birthday) 90 yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) London England		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Louis Cohen		14. MOTHER'S MAIDEN NAME Ezra Cohen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mr. George Giller		Address Same as 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION 421 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) 6 YEARS			INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from MARCH 1961 to APRIL 25, 1966 , that (I) (we) last saw the deceased alive on APRIL 23, 1966 , and that death occurred at 8:25 M, from causes and on the date stated above.			
22a. SIGNATURE Robert L. Krichmar M.D.		22b. DATE SIGNED APRIL 25 1966	
22c. PHYSICIAN'S NAME (Type) ROBERT L. KRICHMAR		22d. ADDRESS 7733 MARLA MENUE N.W. WASHINGTON D.C. 20062	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-27-1966	23c. NAME OF CEMETERY OR CREMATORY Cypress Hills Cemetery	23d. LOCATION (City or Town) (County) (State) Brooklyn, N. Y.
24. FUNERAL DIRECTOR Goldberg Funeral Home ADDRESS 4217-9th St. NW		25a. REC'D BY REGISTRAR APR 27 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 58 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5212 Danbury Road b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Jane Parker Russell			4. DATE OF DEATH Month April Day 22 Year 19 66						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 March 1924		9. AGE (In years last birthday) 42 IF UNDER 1 YEAR Months 1 Days 21 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Benjamin Parker					14. MOTHER'S MAIDEN NAME Florence Moore				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. Not Available		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md. 20014				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonia with hemorrhagic pleural effusions 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myelogenous Leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 								INTERVAL BETWEEN ONSET AND DEATH 10 days 4 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 23, 1966 , to April 22 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 22 19 66 , and that death occurred at 7:10 p.m. from the causes and on the date stated above.									
22a. SIGNATURE Wesley M. Vietzko								22b. DATE SIGNED 23 April 1966	
22c. PHYSICIAN'S NAME (Type) Wesley M. Vietzko, M.D.					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 4-23-66			23b. DATE THEREOF 4-23-66		23c. NAME OF CEMETERY OR CREMATORY Spring Grove Cem.		23d. LOCATION (City, town or county) (State) Darien, Conn.		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland					25a. REC'D BY REGISTRAR APR 26 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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The Clinical Center, Bethesda, Md. 20814 - 2112 Executive Road

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James

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1 March 1974

Female, white

U.S.A.

Connecticut

Hone

Connecticut

Physician records

Benjamin Barker

The Medical Record

Not available The Clinical Center, Bethesda, Md. 20814

Physician

Physician records of the Clinical Center, Bethesda, Md. 20814

Physician records of the Clinical Center, Bethesda, Md. 20814

February 12 08 10 April 12 08

7:10

April 22 08

2 23 April 1974

The Clinical Center, Bethesda, Md. 20814

Institute of Health, Bethesda, Md. 20814

Dr. W. J. Foster, M.D.

APR 2 1974

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b Rockville d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Resmor Sanitarium		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS Sheraton Park Hotel e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cora M. Ruth		4. DATE OF DEATH Month April Day 22 Year 1966	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/21/85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Christian Walker		14. MOTHER'S MAIDEN NAME Geheber Rd.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Robert W. Ruth, Son		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) circulatory collapse 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERY DISEASE DUE TO (c) ARTERIO SCLEROTIC HEART DISEASE 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) uremia, mild aneurysm, abdominal, moderate		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) D. N. A.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) D. N. A.		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/9 , 19 64 to 4/22 , 19 66 , that (I) (we) last saw the deceased alive on 4/22 , 19 66 , and that death occurred at 5:25 P.M., from the causes and on the date stated above.			
22a. SIGNATURE Charles Savarose		22b. DATE SIGNED 4/23/66	
22c. PHYSICIAN'S NAME (Type) CHARLES SAVAROSE, MD.		22d. ADDRESS 1125 ROCKVILLE PIKE ROCKVILLE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/26/66	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City, town or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., Wash., D.C.		25a. REC'D BY REGISTRAR APR 26 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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